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HOSPITAL INCIDENT REPORTING SYSTEMS DO NOT CAPTURE MOST PATIENT HARM

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OBJECTIVES

1. To describe how hospitals use incident reporting systems and incident reports.
2. To determine the extent to which hospital incident reporting systems capture patient harm that occurs within hospitals.
3. To determine the extent to which accreditors review incident reporting systems when assessing hospital compliance with Federal requirements to track instances of patient harm.

BACKGROUND

The term "adverse event" describes harm to a patient as a result of medical care. This report is one in a series about adverse events in hospitals. Hospitals must track and analyze instances of patient harm as a condition of participation in the Medicare program. Incident reporting systems are a common means that hospitals use to meet this condition. Hospitals can demonstrate their compliance with this and all other conditions through a survey by a State survey agency or accreditation under an approved Medicare accreditation program. To standardize hospital event reporting, the Agency for Healthcare Research and Quality (AHRQ) developed a set of event definitions and incident reporting tools known as the Common Formats.

In a 2010 report, the Office of Inspector General found that 13.5 percent of hospitalized Medicare beneficiaries experienced adverse events during their hospital stays that resulted in prolonged hospitalization, required life-sustaining intervention, caused permanent disability, or resulted in death. An additional 13.5 percent experienced temporary harm events that required treatment. For this report, we collected incident reports from hospitals where these adverse and temporary harm events (events) occurred and interviewed administrators from hospitals and representatives of accreditors.

FINDINGS

All sampled hospitals had incident reporting systems to capture events, and administrators we interviewed rely heavily on these systems to identify problems. All of the 189 hospitals we surveyed reported using incident reporting systems designed to capture instances

of patient harm. Administrators from all hospitals with reported events (34 hospitals) indicated that they rely on incident reporting systems to capture a large portion of the information about events that they use to conduct patient safety improvement activities. The administrators acknowledged that incident reporting systems provide incomplete information about how often events occur, but they continue to rely on the systems primarily because they value staff accounts of events.

Hospital staff did not report 86 percent of events to incident reporting systems, partly because of staff misperceptions about what constitutes patient harm. Of the events experienced by Medicare beneficiaries discharged in October 2008, hospital incident reporting systems captured only an estimated 14 percent. In the absence of clear event reporting requirements, administrators classified 86 percent of unreported events as either events that staff did not perceive as reportable (62 percent of all events) or that staff commonly reported but did not report in this case (25 percent).

Nurses most often reported events, typically identified through the regular course of care; 28 of the 40 reported events led to investigations and 5 led to policy changes. Nurses most often identified events through patient observation and routine hospital safety assessments. Information regarding one-quarter of events was not accessible to the staff responsible for monitoring patient safety within the hospitals and for making policy changes. Hospitals investigated the events they considered most likely to yield information that would inform quality and safety improvement efforts and made few changes to policy or practices as a result of reported events.

Hospital accreditors reported that in evaluating hospital safety practices, they focus on how event information is used rather than how it is collected. Accreditors view incident reports within the context of larger hospital quality and patient safety efforts. Officials indicated that to assess hospitals, surveyors are most likely to review the results rather than review the methods used to track hospital adverse events. Surveyors would not specifically investigate these methods, such as incident reporting systems, unless evidence of a problem emerged through the survey process.

RECOMMENDATIONS

Because hospitals rely on incident reporting systems to track and analyze events, improving the usefulness of these systems is critical to hospital efforts to improve patient safety. As Federal health care research and oversight agencies, AHRQ and the Centers for Medicare & Medicaid Services (CMS) are positioned to provide guidance and incentives to hospitals to use incident reporting systems more fully. We recommend the following actions:

AHRQ and CMS should collaborate to create a list of potentially reportable events and provide technical assistance to hospitals in using the list. AHRQ and CMS should create and promote a list for use by hospitals, other health care providers, and clinical educators, such as medical and nursing schools. The list would educate hospital staff about the full range of patient harm that occurs in hospitals and would assist hospital administrators in assessing incident reporting systems. AHRQ and CMS should make it clear in promoting the list that listed events do not need to be reported outside the hospital, but rather that the list is a learning tool intended to broaden and improve staff understanding. The agencies could promote this list through guidance and training documents aimed at hospitals, other health care settings, and clinical education settings, as well as through guidance documents to State and accrediting surveyors. AHRQ could also promote the list through technical assistance targeted at encouraging hospital use of the Common Formats.

CMS should provide guidance to accreditors regarding surveyor assessment of hospital efforts to track and analyze events and should scrutinize survey processes when approving accreditation programs. CMS is testing draft interpretive guidelines for surveyors regarding the requirement to track and analyze events. We recommend that this guidance include information about how surveyors should assess the adequacy of hospital event collection efforts, including incident reporting systems, and should include the list of potentially reportable events to be developed by AHRQ and CMS. CMS should also suggest that surveyors evaluate the information collected by hospitals using AHRQ's Common Formats. Additionally, CMS should scrutinize survey standards for assessing hospital compliance with the requirement to track and analyze events and reinforce assessment of incident reporting systems as a key tool to improve event tracking.

AGENCY COMMENTS

We received comments on the draft report from AHRQ and CMS. AHRQ concurred with our recommendation directed to it, stating that it will collaborate with CMS to create a list of potentially reportable events and provide technical assistance to hospitals in using the list. AHRQ stated that it will meet with CMS staff to continue collaboration on the potential use of Common Formats with surveyors and hospital adverse event reporting systems. CMS concurred with both of our recommendations, stating that strengthening hospital reporting systems and practices is an essential component of efforts to prevent patient harm. CMS stated that a voluntary list of adverse events used for informational purposes could be highly beneficial for improving incident reporting practices. CMS also indicated that it is developing draft guidance for surveyors regarding assessment of patient safety improvement efforts within hospitals.

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BACKGROUND

Office of Inspector General Reports About Adverse Events

This report follows a series of Office of Inspector General (OIG) reports about adverse and temporary harm events in hospitals.[1] For this series of reports, we defined "adverse events" as significant harm experienced by patients as a result of medical care. We defined "temporary harm events" as harm that required medical intervention but did not cause lasting harm. Although an adverse or temporary harm event indicates that the care resulted in an undesirable clinical outcome and may involve medical errors, adverse events do not always involve errors, negligence, or poor quality of care and may not always be preventable.[2] Practices and policies to ensure patient safety and reduce the incidence of adverse events often involve identifying and learning from causes and contributing factors. Efforts to meet this objective often rely on hospital-staff-generated incident reports.

Hospital Incident Reporting Systems

Hospitals use incident reporting systems to monitor adverse events and other patient safety issues.[3] Incident reporting systems, which vary in design and functionality, capture and maintain reports of patient-safety-related events documented by physicians, nursing staff, or other hospital staff. Reported patient safety events could include

[1] The most recent reports in the series are Adverse Events in Hospitals: Methods for Identifying Events, OEI-06-08-00221, March 2010; and Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries, OEI-06-09-00090, November 2010.

[2] R.M. Wachter, Understanding Patient Safety, McGraw-Hill, 2008.

[3] D.O. Farley, "Adverse-Event-Reporting Practices by US Hospitals: Results of a National Survey," Quality and Safety in Health Care, 17, 2008, pp. 416–423.

adverse events, "near-misses," or situations with the potential to harm patients. Completed reports typically include first-person accounts and other descriptive information about the events. Incident reports may also include information about the impact of the event on the patient and the causes of the events, if known. Hospital staff can submit reports in writing or electronically, depending on the reporting system. See Appendix A for an example of an incident report.

The 1999 Institute of Medicine (IOM) report, To Err Is Human: Building a Safer Health System, encouraged the use of incident reporting systems, maintaining that hospitals can address patient safety problems only if events are identified and adequately described by caregivers.[4, 5] In a followup report, IOM recommended that hospitals develop comprehensive patient safety improvement plans based on data collected from internal incident reporting systems and other event detection methods.[6] IOM advised hospitals to analyze these data to identify the causes of events and to develop strategies to prevent recurrence.

Incident reporting systems have limitations. First, it can be difficult to determine incidence rates based on reported data because of variability in the rate and consistency of reporting.[7] Second, research suggests that incident reporting systems capture only a small percentage of adverse events and that some categories of events are underrepresented.[8, 9] Additionally, the rate and consistency of event reporting by hospital staff often varies.[10]

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[4] L.T. Kohn, J.M. Corrigan, and M.S. Donaldson, eds., To Err Is Human: Building a Safer Health System, A Report of the Committee on Quality of Health Care in America, 2000, p. 100.

[5] P.J. Provonost, "Using Incident Reporting to Improve Patient Safety: A Conceptual Model," Journal of Patient Safety, 3(1), 2007, pp. 27–33.

[6] P. Aspden, Patient Safety: Achieving a New Standard for Care, The National Academies Press, Washington, D.C., 2004.

[7] Agency for Healthcare Research and Quality (AHRQ), Users Guide: AHRQ Common Formats Version 1.1, March 2010, p. 1-2.

[8] T.K. Nuckols, "Rates and Types of Events Reported to Established Incident Reporting Systems in Two US Hospitals," Quality and Safety in Health Care, 16, 2007, pp. 164–168.

[9] OIG, Adverse Events in Hospitals: Case Study of Incidence Among Medicare Beneficiaries in Two Counties, OEI-06-08-00220, December 2008.

[10] AHRQ, Users Guide: AHRQ Common Formats Version 1.1, March 2010, p. 1-2.

Despite these limitations, stakeholders note that incident reporting systems have advantages. These include systems' familiarity among hospital staff and the advantages derived from involving frontline personnel in identifying safety hazards for the organization.[11] Compared to other event detection methods commonly used in hospitals, incident reporting systems are thought to capture a wider range of events at a lower cost to hospitals.[12]

Requirements To Improve Patient Safety by Measuring Adverse Events

As a condition of participation (CoP) in Medicare, Federal regulations require that hospitals develop and maintain a Quality Assessment and Performance Improvement (QAPI) program.[13] To satisfy QAPI requirements, hospitals must "track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital."[14] To accomplish this, hospitals must "measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital service, and operations."[15] Federal regulations do not specify means for meeting the requirements, nor do they explicitly define what "quality indicators" or "adverse patient events" hospitals should measure.[16]

Hospital Accreditation

Most hospitals (89 percent) demonstrate their compliance with QAPI and the other CoPs to the Centers for Medicare & Medicaid Services (CMS) through a survey by a State survey agency or accreditation under an approved Medicare accreditation program, a process known as "deeming."[17, 18] Currently, three national accreditors review hospitals: the Joint Commission, the American Osteopathic Association (referred

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[11] AHRQ, Voluntary Patient Safety Event Reporting (Incident Reporting). Accessed at http://www.psnet.ahrq.gov/primer.aspx?primerID=13 on March 31, 2011.

[12] K.G. Shojania, "The Elephant of Patient Safety: What You See Depends on How You Look," The Joint Commission Journal on Quality and Patient Safety, 36, 2010, pp. 399–401.

[13] 42 CFR § 482.21.

[14] 42 CFR § 482.21(c)(2).

[15] 42 CFR § 482.21(a)(2).

[16] 68 Fed. Reg. 3435, 3438–39 (Jan. 24, 2003).

[17] CMS, CMS Financial Report: Fiscal Year 2009.

[18] Social Security Act, § 1861(e), 42 U.S.C. § 1395x(e).

to as "HFAP"), and Det Norske Veritas (DNV) Healthcare.[19] The Secretary of Health and Human Services (HHS) granted deeming authority to each of these accreditors after CMS determined that the accreditation programs' standards met or exceeded the requirements listed in the CoPs.[20] Hospitals that do not opt for accreditation can be certified as meeting CoPs by State survey and certification agencies.[21] The accreditation and certification processes rely on periodic, onsite inspections—called surveys—of hospitals. CMS provides guidance to State survey and certification agencies for conducting surveys in its State Operations Manual.[22]

All three accreditors include QAPI-based quality, safety, and performance provisions in their hospital requirements. These provisions, like the QAPI CoP, typically include identifying adverse events as part of broader quality and performance improvement requirements and do not specify the means hospitals should use to identify and analyze events. For example, one accreditor's manual specifies that hospitals should "use data and information to guide decisions" and have an "organization-wide, integrated patient safety program."[23] This is similar to the QAPI CoP requirement that hospitals "must develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program."[24] Each of the three accreditors defines what constitutes an adverse event. Their lists of events vary and include events that cause harm to patients, such as adverse medication reactions; and process breakdowns that could lead to harm, such as erroneous laboratory reports.[25, 26]

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[19] CMS, CMS-Approved Accreditation Organization Contact Information, 2011.

[20] Social Security Act, § 1865, 42 U.S.C. § 1395bb.

[21] The remaining 11 percent of hospitals were certified in compliance with the CoPs by State survey and certification agencies. According to CMS, the percentage of hospitals certified by State survey and certification agencies will begin to decrease after 2010 because CMS has directed these agencies to prioritize other activities over initial hospital certifications. CMS, CMS Financial Report Fiscal Year: 2010, pp. 130–131.

[22] CMS, State Operations Manual, Pub. 100-07.

[23] The Joint Commission, Hospital Accreditation Operations Manual, LD.03.02.01 and LD 04.04.05.

[24] 42 CFR § 482.21.

[25] The Joint Commission, Hospital Accreditation Operations Manual, PI.01.01.01.

[26] DNV, NIAHO Standards and Interpretive Guidelines, QM 7 SR 1-18.

AHRQ's Common Format Event Reporting Tools

To support and standardize hospital event reporting, AHRQ developed a set of event definitions and incident reporting tools known as the Common Formats.[27] AHRQ defines the Common Formats as "clinical definitions and technical requirements developed for the uniform collection and reporting of patient safety data." AHRQ developed the Common Formats to assist hospitals in developing standardized reporting methods and in reporting information to PSOs.[28] Under AHRQ's oversight, PSOs receive adverse event reports from hospitals, analyze the reports in aggregate, and provide hospitals with analysis and recommendations for improving patient safety.[29] AHRQ announced Common Formats Version 1.1 in the Federal Register on March 31, 2010. Version 1.1 includes instructions for reporting events that harm patients and "near-misses" (circumstances that have the capacity to cause harm).[30]

The Common Formats include descriptions of patient safety events and unsafe conditions to be reported, specifications for aggregate event reports and individual event summaries, delineation of data elements to be collected for specific types of events, a user's guide, and technical specifications for electronic data collection and reporting. The Common Formats allow PSOs to aggregate event and contributing factor information from across hospitals for comparisons and trend analyses. The Common Formats' three event reporting forms focus on specific areas: information describing the event, information describing the impact on the patient, and summary and contributing factor information. The Common Formats also contain event-specific modules that provide additional detail for high-volume or high-harm events.

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[27] AHRQ developed the Common Formats as part of HHS's congressional mandate to provide technical assistance to Patient Safety Organizations (PSO) on matters such as methodology, communication, data collection, and privacy concerns. Public Health Service Act, § 925, 42 U.S.C. § 922b-25.

[28] Sections 923 and 924 of the Public Health Service Act, which were added by the Patient Safety and Quality Improvement Act of 2005, required HHS to determine that PSOs meet certain criteria to perform "patient safety activities" and establish a network of patient safety databases to receive, analyze, and report on patient safety information submitted by the PSOs. Patient Safety and Quality Improvement Act of 2005, P.L. 109-41 § 2; Public Health Service Act, §§ 923 and 924; 42 U.S.C. §§ 299b-23 and 24.

[29] 73 Fed. Reg. 70733 (Nov. 21, 2008).

[30] 75 Fed. Reg. 16140, 16141-42 (Mar. 31, 2010).

National Incidence of Adverse Events

In a November 2010 report, OIG estimated the national incidence rate of adverse and temporary events in hospitals.[31] We found that 27 percent of hospitalized Medicare beneficiaries experienced at least one adverse event (13.5 percent) or temporary harm event (13.5 percent) during hospitalizations that ended in October 2008. These rates were projected to all beneficiaries hospitalized during October 2008.

To determine the national incidence rate, we selected a sample of beneficiaries. Of the 999,645 beneficiaries discharged from acute care hospitals during October 2008, we selected a random sample of 785. We excluded 5 beneficiaries as ineligible because the hospitals where they were treated were under OIG investigation, resulting in a sample of 780 beneficiaries. These sample beneficiaries had a combined total of 838 hospital stays with discharges in October 2008.

To identify adverse events experienced by sampled beneficiaries, we conducted a two-stage review of their medical records. During the first stage, we identified cases that met one or more of the following conditions: (1) a certified medical coder identified a diagnosis in the Medicare claims data that was coded as not present when the beneficiary was admitted to the hospital, (2) nurse reviewers found evidence of a potential adverse event in the medical records, or (3) the beneficiary was readmitted to the hospital within 30 days after discharge following a hospital stay ending in October 2008.[32]

Based on findings from the first stage of review, we advanced 420 cases to the second stage, in which physicians reviewed the beneficiaries' hospital medical records to identify events. Physicians identified 128 adverse events that met at least one of three criteria: (1) events on the National Quality Forum's (NQF) list of Serious Reportable Events;[33] (2) events for which CMS will no longer pay a

[31] OIG, Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries, OEI-06-09-00090, November 2010.

[32] The nurse reviewers used a modified version of the Institute for Healthcare Improvement's Global Trigger Tool. F.A. Griffin and R.K. Resar, IHI Global Trigger Tool for Measuring Adverse Events, Institute for Health Care Improvement Innovation Series 2007, pp. 4–5.

[33] NQF, Serious Reportable Events, October 2008.

higher Medicare reimbursement (known as hospital-acquired conditions (HAC));[34] and (3) events resulting in a prolonged hospital stay, permanent harm, life-sustaining intervention, or death. Physicians also identified 174 temporary harm events, which we defined as events requiring intervention but not rising to the level of patient harm associated with adverse events. In total, they identified 302 patient harm events.

METHODOLOGY

Scope

This report estimates the national rate at which hospital incident reporting systems captured events experienced by Medicare beneficiaries discharged from acute care hospitals during October 2008. This reporting rate and hospital administrators' explanations for the reasons staff did not report events are projectable nationwide to all Medicare beneficiaries hospitalized during this period. To determine the estimated rate of reporting, we requested incident report information from the 195 hospitals associated with the 302 events that we identified for the national incidence study. This report also provides findings regarding hospital use of incident reporting systems and information included in reports, which pertain only to the sample of reported events and are not projectable. Lastly, this report provides information about how hospital accreditors assess incident reporting systems during hospital surveys.

Data Collection

Hospital surveys. To determine whether the hospitals associated with the events had incident reporting systems designed to capture patient harm events, we sent a survey to each of 195 hospitals associated with the events. In the survey, we asked the hospitals to describe each of the incident reporting systems they used to capture event information and the types of information they expected to collect through the systems. We received responses from 189 of the 195 hospitals describing 293 of the 302 events (a 97-percent response rate).

[34] CMS, Hospital-Acquired Conditions (HAC) in Acute Inpatient Prospective Payment System (IPPS) Hospitals, October 2010.

Information requests. To identify which of the 302 events hospitals captured in internal incident reporting systems, we sent information requests to each of the 195 hospitals associated with the events. Each information request identified the patient who experienced the event, the stay in which the event occurred, and a description of the event that physician reviewers identified. We asked each of the hospitals whether the identified events had been captured by an incident reporting system and, if so, to provide supporting documentation. If an event was not captured, we asked the hospital for an explanation. Because we sent the information requests along with the hospital surveys and received information from each of the hospitals that returned a survey, we received information for 293 events (a 97-percent response rate).

We also obtained supporting documentation from hospitals for all captured events. Supporting documentation included incident reports, copies of infection-tracking logs, skin-care management logs, peer review documentation, and patient safety committee minutes. See Appendix B for a description of the information in the completed incident reporting system forms provided by the hospitals.

Hospital interviews. We conducted structured interviews with administrative staff from each of the 34 hospitals in which an event was reported to an incident reporting system.[35] We conducted the interviews in response to a request from CMS to determine what actions the hospitals took following the reports of events. We asked each hospital administrator to describe how information about an event was shared within the hospital, the extent to which staff analyzed the event, and whether the reporting of the event led to policy or process changes. Findings pertaining to these interviews are not projectable and represent only the actions of the 34 hospitals.

Accreditation organization interviews. We interviewed staff from the three hospital accreditors. We gathered information on the extent to which the accreditors review incident reporting systems when evaluating hospital compliance with accreditation standards related to quality and safety.

[35] In almost all cases, we interviewed the hospitals' risk managers, patient safety officers, and/or quality improvement specialists. We refer collectively to these staff members as hospital administrators.

We focused on accreditors because they certified compliance for 89 percent of all hospitals in 2008. Within our sample of 189 hospitals, CMS deemed 98 percent to be in compliance with Medicare's CoPs following accreditation by one of the three hospital accreditors: the Joint Commission accredited 89 percent of sample hospitals, HFAP accredited 5 percent, and DNV accredited 4 percent.

Data Analysis

We calculated the percentage of events that hospitals indicated their incident reporting systems captured among the 293 events identified in our national sample and included in our analysis. We also calculated percentages for the reasons hospitals reported that incident reporting systems did not capture the other events. We computed all rates and corresponding 95-percent confidence intervals using the computer program Sudaan, which provides standard errors for complex sampling designs. See Appendix C for estimates, confidence intervals, and key statistics.

Limitations

Hospitals may not have provided information about all events captured by incident reporting systems. This could be due to a number of factors, including the 2-year interval between the events and our information request, concern about preserving the confidentiality of sensitive report documents and potential liability in releasing such information, and lack of effective hospital recordkeeping. These limitations could result in our underestimating the extent to which hospital incident reporting systems capture events.

Standards

This study was conducted in accordance with the Quality Standards for Inspection and Evaluation issued by the Council of the Inspectors General on Integrity and Efficiency.

All sampled hospitals had incident reporting systems to capture events, and administrators we interviewed rely heavily on these systems to identify problems

All of the 189 hospitals in which an event occurred reported using general incident reporting systems designed to capture information about instances of patient harm from across hospital departments. Additionally, most hospitals used specialized incident reporting systems to capture events within specific hospital departments, such as pharmacy; or to capture specific types of adverse events, such as patient falls. The most common specialized systems focused on infections, medication events, and patient complaints. See Table 1 for the types of incident reporting systems that hospitals used to capture events.

Table 1: Types of Hospital Incident Reporting Systems (n=189)

Type of System	Number of Hospitals With System
General incident reporting system designed to capture all instances of patient harm	**189**
Specialized incident reporting system	**132**
Infection tracking	98
Pharmacy or medication error tracking	43
Patient complaint tracking	40
Security issues	14
Harm to staff	7
Regulatory compliance	4

Source: OIG analysis of information requests completed by the 189 hospitals where the 293 events occurred.

Hospital administrators indicated that they encourage staff to report any instance of patient harm to incident reporting systems

During followup interviews, administrators at 34 of the 189 hospitals indicated that they expect staff to report any instance of patient harm and even circumstances that could lead to harm. They explained that staff have broad instructions to report all patient safety problems. Additionally, these hospitals typically provide training focused on reporting specific types of events commonly understood as patient harm, such as pressure ulcers. However, none of the hospitals maintained a list of events required to be reported to incident reporting systems.

Hospital administrators we interviewed explained that they rely heavily on incident reporting systems to identify safety problems

Administrators from all 34 hospitals indicated that they rely on incident reporting systems to capture much of the information used to conduct patient safety improvement activities. Many administrators reported that they combine reported information with data collected through other event detection methods, including medical record reviews (18 administrators), administrative data screening (17), manual or automated review for evidence of hospital-acquired infections (8), and postprocedure checklists to identify complications (8).

Administrators also reported a number of benefits to capturing information through incident reporting systems. Foremost, administrators explained that reports from staff who are directly involved with events provide greater detail and insight about the patient, circumstances, and possible contributing factors (such as specific breakdowns in processes) than information provided by other event detection methods. Other reported benefits of incident reporting systems include identifying a broad range of events (reported by 12 administrators) and focusing staff attention on patient safety issues (reported by 9).

Hospital administrators we interviewed also noted several factors that limit the usefulness of incident reporting systems

Although administrators largely expressed confidence in their systems to generate useful information, many identified limitations. Twenty-two of the thirty-four administrators indicated that underreporting of events by hospital staff leads to inaccurate measurement of patient harm. Administrators expressed concern that underreporting can affect patient safety efforts by potentially skewing resources toward prevention of more easily identifiable occurrences that happen at a point in time (such as patient falls) rather than complex events that occur over a longer period and are more difficult to detect (such as blood clots). Sixteen administrators noted that reports to their systems often require additional investigation, such as a root-cause analysis, to provide meaningful information. Further, 10 administrators noted that it is sometimes difficult to interpret data from their systems. For example, an increase in reports about a certain type of event could reflect either an increase in occurrences or improved reporting.

Hospital staff did not report 86 percent of events to incident reporting systems, partly because of staff misperceptions about what constitutes patient harm

Despite the existence of incident reporting systems, hospital staff did not report most events that harmed Medicare beneficiaries. Of the events experienced by a national sample of beneficiaries discharged in October 2008, hospital incident reporting systems captured only an estimated 14 percent of events.[36] Further, hospital staff reported only 2 of the 18 most serious events in our sample (i.e., those events that resulted in permanent disability or death). Serious events not captured by incident reporting systems included hospital-acquired infections, such as a case of septic shock leading to death; and medication-related events, such as four cases of excessive bleeding because of the administration of blood-thinning medication that also led to death. Incident reporting systems did not capture any of the five NQF Serious Reportable Events and only one of the eight Medicare HAC events in our sample. Medicare does not require hospitals to capture information about these events through incident reporting systems. However, because events on the NQF and Medicare HAC lists are widely recognized among medical professionals as constituting patient harm, many among the public and in the health care community may expect them to be reported by hospital staff.

Administrators conceded that it was likely not clear to staff which events to report, given the wide range of patient harm that can occur in hospitals

In the absence of clear reporting requirements for events, it is difficult for staff to determine hospital expectations for reporting incidents. Although administrators indicated that they want staff to report all instances of harm, when asked about specific events administrators conceded that staff may often be confused about what constitutes harm and is, therefore, reportable. For each of the events that staff did not report (86 percent of all events), hospital administrators indicated whether they would expect staff to recognize the events as reportable patient harm. They classified most unreported events as events that hospital staff most likely did not perceive as reportable (62 percent of all events) and the remaining unreported events (25 percent) as events that

[36] Because we found no statistically significant difference in reporting rates between adverse and temporary harm events, we refer to adverse events and temporary harm events collectively as "events." The Cochran-Mantel-Haenszel chi-square test was not significant at the 95-percent confidence level (p=0.7380).

staff commonly reported but did not report in this particular case. See Table 2 for detailed information on why staff didn't report events.

Table 2: Events by Reporting Category and Reasons Administrators Gave for Why Staff Did Not Report (n=293)

Event Category	Percentage of All Events
Events Captured by Incident Reporting Systems (n=40)	14%
Events Not Captured by Incident Reporting Systems (n=253)	86%
Event was not reported; staff did not perceive event as reportable because:	62%*
Event was not caused by a perceptible error	12%
Event was an expected outcome or side effect	12%
Event caused little harm and/or harm was ameliorated	11%
Event was not on hospital's mandatory reporting list	9%
Event occurs frequently in hospitals	8%
Event symptoms became apparent after discharge	5%
Event occurred in patient with a history of similar events	4%
No reason given for why staff did not perceive event as reportable	2%
Event was not reported although event type is commonly reported	25%*
Total	100%

Source: OIG analysis of the 293 information requests completed by hospitals where events occurred.

* Percentages do not sum to 86 percent because of rounding.

For the 62 percent of events not reported because staff did not perceive them as reportable, administrators indicated that staff likely did not recognize that the event caused harm or realize that they should complete a report. The most common reason administrators gave for staff underreporting was that no perceptible error occurred (12 percent), indicating that staff commonly equate the need to complete incident reports with medical errors. Other reasons for underreporting include staff becoming accustomed to common occurrences and therefore not submitting reports, such as events that were expected side effects (12 percent) or occurred frequently (8 percent). For example, staff reported only 1 of 17 sample events related to catheter usage (e.g., infection and urinary retention), a common cause of harm to Medicare beneficiaries. In other cases, the symptoms of the event did not become apparent until after the hospital discharged the patient (5 percent). Administrators reported that such events are unlikely to be captured by hospital incident reporting systems unless patients return to the hospital and staff uncover a causal link with the prior hospitalization.

Administrators indicated that the remaining 25 percent of events were types of harm that staff commonly report to incident reporting systems and that they would expect staff to report. Administrators believed these events were clearly reportable because hospital staff received specific training to report this type of event and/or the event had characteristics that staff commonly associated with patient harm, such as the result of a specific action. For example, staff reported all patient falls, an event that is often the focus of hospital safety efforts. If hospital staff had reported the 25 percent of events that are commonly reported, the rate of reporting would have increased from 14 to 38 percent. It is difficult to determine why staff did not report these events, but administrators suspected both limited staff time and misperceptions that other staff would report the event.

Nurses most often reported events, typically identified through the regular course of care; 28 of the 40 reported events led to investigations and 5 led to policy changes

Information in incident reports typically described the reported event and its impact on the patient. Administrators from each of the hospitals with a reported event (34 hospitals) indicated that they attempted to use the information to improve patient safety, typically as a starting place for further investigation and analysis. Hospitals conducted investigations for two-thirds of events, although few events resulted in changes to hospital policies or practices.

Nurses reported 31 of the 40 events to incident reporting systems, with the remaining 9 events reported by a variety of other hospital staff

The hospitals designed most incident reporting systems to allow reporting by any staff member or associated clinician, such as physicians and therapists; in some cases the systems also allowed reporting by parties other than hospital staff, such as patients and families. Hospital administrators said that they encourage all staff to report, including those in specialized departments and those following patients through a course of care. For example, one administrator said that his or her hospital relies on case managers to identify events that transpire over multiple days or are the result of patient transfers between departments.

Nurses discovered 24 reported events through observation of patients in the regular course of care. Nurses and other staff, such as infection control specialists and case managers, discovered the remaining 16 reported events by completing hospital safety assessments designed to identify problems. When staff identified events through hospital safety assessments, the results of the assessments prompted staff to create incident reports. Staff identified 10 of these 16 events using criteria-based patient evaluations (such as skin assessments required for all patients at risk for developing pressure ulcers) and the remaining 6 events through more general screening of patient records (such as a nurse's review of patient condition at the end of a shift). See Table 4 for a list of how staff first identified the events they reported.

Table 4: Hospital Detection Methods That Identified Events Reported to Incident Reporting Systems (n=40)

Method of Event Identification	Events Identified
Identified by Staff Through Patient Observation During the Regular Course of Care	**24**
Identified After Criteria-Based Patient Status Reviews	**10**
Skin integrity assessment	3
Blood culture analysis to identify patients likely to develop an infection	2
Chart review of patient who met hospital-defined criteria	1
Medication review following emergency rescue medication	1
Medication review following potential contraindication	1
Potential complication questionnaire following procedure	1
Chart review following patient complaint	1
Identified Through Routine Screening of Hospital Tests	**6**
Blood culture analysis	2
Case management review	2
Skin care assessment	2

Source: OIG analysis of interviews with administrators at hospitals where the 40 reported events occurred.

Information regarding one-quarter of events was not immediately accessible to the staff responsible for monitoring patient safety within hospitals

Hospital staff reported 29 events to general incident reporting systems that staff responsible for hospitalwide event tracking and monitoring (e.g., patient safety staff, such as risk managers or patient safety officers) used to monitor event occurrence. These systems either automatically sent an alert to relevant staff (e.g., event specialists or department managers) or stored the event in a database for later

review. The hospital administrators we interviewed reported that patient safety staff reviewed events captured by these systems daily or at the end of each shift.

Hospital staff reported the other 11 events to department-specific specialized systems (e.g., infection tracking systems), making them immediately accessible to centralized patient safety staff. In most of these cases, centralized patient safety staff became aware of the events only after receiving aggregate event summaries generated by these systems. Hospital administrators reported that patient safety staff generally do not have immediate access to the information collected in these specialized systems and rely on the system managers to forward reports periodically. For example, in one instance when a nurse entered a pressure ulcer event into a skin wound event tracking log, patient safety staff had access to the information only after a summary was forwarded at the end of the month. Hospital administrators also indicated that high rates of reporting to department-specific systems that are not readily accessible to centralized patient safety staff can lead to compartmentalization of information. They stated that this can impede efforts to track and monitor adverse events across the hospital.

Hospitals investigated the events they considered most likely to inform quality and safety improvement activities

The hospital administrators we interviewed reported that they investigated and analyzed 28 of the 40 events for evidence of system failures or medical errors to inform quality and safety improvement activities. Patient safety staff conducted half of these investigations (14 events); the rest were conducted by managers of departments where the events occurred or by clinical event specialists, such as wound care nurses or infection-control specialists. These reviews ranged from informal reviews immediately following the incidents to structured analyses intended to comprehensively identify errors that contributed to adverse events (i.e., root-cause analyses). Hospital administrators reported that they did not investigate the remaining 12 events because they suspected that the events were isolated incidents unlikely to recur. Therefore little benefit would derive from a quality improvement investigation.

The most common type of investigation was a clinical review of a single event, but hospital administrators reported that they regularly analyze events in aggregated event reviews. Aggregated event reviews involved reviewing data about multiple events to identify trends and common causes. Administrators indicated that clinical reviews are usually conducted by patient safety staff or department managers in collaboration with the staff members directly involved with the event. These clinical reviews were similar to root-cause analyses but contained less detail and used fewer resources. The most frequently discussed questions during these clinical reviews included whether staff correctly assessed patients before treatment began; whether the standard of care was met by the attending physicians; and what contributing factors led to the event, such as medication mislabeling or poor communication during shift changes.

Hospitals made few changes to policies or practices as a result of the reported events

Hospital administrators reported that only 5 of the 40 sample incident reports led to a hospital policy or practice change. Two of these events led directly to changes in hospital policy or practice, and staff included the other three in an aggregate event review that led to changes. According to administrators, the remaining 35 reported events did not result in a policy or practice change primarily because hospitals reviewed the event information and determined that the occurrences did not represent systemic quality problems within the hospitals. Administrators reported that changes to hospital policies or practices as a result of a single event are rare unless the event is found to represent a systemic problem within the hospital. In other cases, hospital administrators reported that they may already have procedures in place to avoid a specific type of event. For example, hospitals may use special pressure-reducing mattresses and have rigorous policies and training regarding patient turning, yet still see some pressure ulcers develop.

Hospital accreditors reported that in evaluating hospital safety practices, they focus on how event information is used rather than how it is collected

In interviews, officials from hospital accreditors noted the importance of incident reporting systems to hospital patient safety efforts. However, they also reported that they are unlikely to scrutinize the effectiveness of event detection methods, such as incident reporting systems, during hospital surveys.

Hospital accreditors view incident reporting systems within the context of larger hospital quality and patient safety efforts

Officials from the three accreditors confirmed that their standards require hospitals to track adverse events to inform safety improvement efforts, as mandated by QAPI CoP, and that hospitals often use incident reporting systems to satisfy this requirement. Officials indicated that their surveyors are directed to assess hospital efforts by reviewing the results of patient safety improvement efforts. Surveyors would not specifically investigate mechanisms of hospital adverse event tracking unless evidence of a problem emerged through their standard survey process.

As an example, one accreditor described how surveyors assessed a hospital's efforts to track hospital-acquired infections. In this case, surveyors focused on the care provided to individual patients as part of the survey protocol. If a selected patient developed an infection, the surveyor would investigate the circumstances of the infection, including whether it was detected by an automated surveillance tool and reported to an incident reporting system. The surveyor reviewed the report and any noted corrective action. Although the review was described as fairly thorough by the official, it was dependent upon whether a selected patient contracted an infection or experienced some other reportable event.

Surveyors may view data in an incident reporting system as part of their review but do little investigation of the specific incident reporting system, the mechanism of reporting, usability by staff, or typical information in the reports (including the frequency of reported events). One accreditation official explained that hospital administrators could choose to demonstrate their incident reporting system as an example of QAPI compliance or could choose to highlight event detection methods, such as an electronic surveillance system or a medical record review process.

Accreditors cited a number of reasons their surveyors do not scrutinize incident reporting systems or other event detection methods during hospital surveys. Most of the reasons rested on the perception that event detection methods are complex and varied. First, hospitals collect event data from a variety of sources, and it can be difficult to discern which information is from a report and which is from a surveillance record or medical record review. Second, surveyors may not have the expertise to assess the reporting mechanism itself and provide recommendations to improve reporting. Third, officials questioned the value of requiring hospitals to collect event information in a particular way, arguing that a prescribed approach may inhibit innovation. Given this, some officials reasoned that it was better to focus on the output than on the systems, but they conceded that this lack of focus on how hospitals collect event information meant there was little scrutiny of the reporting systems' event data that hospitals use to inform their patient safety improvement efforts.

Previous OIG work determined that, despite significant attention from stakeholders in recent years, adverse events continue to pose a serious risk to hospitalized Medicare beneficiaries. Identifying events helps hospital administrators set goals for improvement, direct resources, and assess the effectiveness of prevention strategies. Hospital administrators indicated that, although they employ a number of methods to detect patient safety problems, incident reporting by staff is the primary tool used to identify events. However, we found that incident reporting systems did not capture 86 percent of events that caused patient harm in a national sample of Medicare beneficiaries. Further, hospital staff often did not report events because they did not perceive them as causing reportable patient harm.

AHRQ and CMS are positioned to provide guidance and incentives for hospitals to more effectively track and analyze adverse events. AHRQ oversees critical research efforts, the PSO program, and the Common Format event reporting tools. CMS oversees hospital accreditation, which includes ensuring that hospitals have a data-driven performance improvement plan that meets the standards detailed in the Medicare CoP.

Therefore, we recommend the following:

AHRQ and CMS should collaborate to create a list of potentially reportable events and provide technical assistance to hospitals in using the list

Hospital staff identification of patient harm is critical to the success of patient safety efforts. Hospital administrators reported that the most common reason hospital staff do not report patient harm is that they do not perceive the harm as a reportable event. As such, hospital efforts to improve patient safety may be limited by focusing on only a small subset of events that get more attention because they are more often reported by staff. Given the importance of incident reporting to hospital safety efforts, AHRQ and CMS should take steps to improve reporting by hospital staff.

AHRQ and CMS should collaborate to create and promote a list of potentially reportable events for hospitals, other health care providers, and clinical educators, such as medical and nursing schools. We do not recommend that AHRQ or CMS require hospitals to report the events on the list. Rather, the list of events would educate hospital staff about the full range of patient harm that occurs in hospitals and should be

reported to incident reporting systems. The list should go beyond the fairly rare harm events included in the NQF and Medicare HAC lists and include a comprehensive range of possible patient harm. Events on the list could include those identified in prior OIG work and by other researchers.[37] The list could also include "near-miss" occurrences, given that AHRQ has promoted the reporting of near-misses as important for improving practices. AHRQ and CMS should be clear in publishing the list that they do not require external hospital reporting of listed events, but provide the list to broaden and improve staff understanding.

The two agencies could promote this list as a guidance and training document for hospitals, other health care settings, and clinical education settings, as well as for State and accrediting surveyors. AHRQ could also promote the list through technical assistance targeted at encouraging hospital use of the Common Formats.

CMS should provide guidance to accreditors for assessment of hospital efforts to track and analyze events and should scrutinize survey processes when approving accreditation programs

Under the Medicare QAPI CoP, hospitals must track and analyze adverse events. Administrators indicated that incident reporting systems are critical to identifying and tracking events. Although reporting systems captured few events, we found that accreditors do not routinely assess incident reporting systems or other methods for identifying events during hospital surveys.

CMS is testing draft interpretive guidelines for surveyors regarding the QAPI CoP, including guidance about how surveyors are to assess hospital operations for tracking patient harm. To facilitate more extensive hospital detection of events, we recommend that this guidance include information about how surveyors should assess hospital event collection efforts, including incident reporting systems, and should include the list of potentially reportable events to be developed by AHRQ and CMS (addressed in our first recommendation).

CMS should also suggest that surveyors evaluate the information collected by hospitals and compare it to the data elements of AHRQ's

[37] Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries, OEI 06-09-00090, pp. 51–61. See Appendix D for rates of reporting within the subcategories of events identified in the national incidence study.

Common Format event reporting tools, which include the information that AHRQ has found to be most useful in patient safety efforts. This comparison could serve not only to assess the quality of reported information but also would further promote use of the Common Formats by hospitals in developing their internal incident reporting systems.

Additionally, CMS should scrutinize survey standards for assessing hospital compliance with the requirement to track and analyze events and reinforce assessment of incident reporting systems as a key tool to improve event identification and tracking. Given the low reporting rates and lack of assessment by accreditors during hospital surveys, CMS should ensure that accreditation survey practices bring about a meaningful examination of systems that identify events, including mechanisms for reporting events, and hospital efforts to address underreporting and use information.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

We received comments on the draft report from AHRQ and CMS.

AHRQ. AHRQ concurred with our recommendation to collaborate with CMS in creating a list of potentially reportable events and providing technical assistance to hospitals in using the list. AHRQ stated that it will meet with CMS staff to continue collaboration on the potential use of Common Formats by surveyors and hospital adverse event reporting systems.

CMS. CMS concurred with our recommendations and stated that strengthening hospital reporting systems and practices is an essential component of efforts to prevent patient harm. CMS provided information about future plans to improve patient safety, including the public-private "Partnership for Patients," a national initiative intended to reduce adverse events and complications caused during transitions from hospitals to other health care settings.

In response to our recommendation that CMS collaborate with AHRQ in creating a list of potentially reportable events, CMS stated that a voluntary list of adverse events used for informational purposes could be highly beneficial for improving incident reporting practices, and it has initiated this collaboration. In response to our recommendation that CMS provide guidance to accreditors, CMS stated that it is

developing draft guidance for surveyors regarding assessment of the QAPI CoP within hospitals. This guidance will include the expectation that hospitals provide staff with "detailed, unambiguous instructions on the types of events that should be reported." Further, CMS stated that it will recommend that hospitals use both the list of potentially reportable events and the AHRQ Common Formats in developing these staff instructions.

For the full text of AHRQ and CMS comments, see Appendix E.
We made minor changes to the report based on technical comments.

Example Incident Report

Below is a reproduction of an incident report we received during data collection. We redacted all patient and hospital information.

Incident Info: Patient Fall	**People Involved:**
Incident Number: 8726	(Reporting Employee Name)
Log Date: 10/01/2008 2:25:21 PM	**Other People Involved:**
Incident Date: 10/01/2008 2:20:00 PM	Witness
Location: BATHROOM	(Attending Physician Name)
Primary Person Involved: (Patient Name)	(Employee Reviewer Name)
Account Number:	(Employee Reviewer Name)
Birth Date:	(Employee Reviewer Name)

Comments/Incident Description/Additional Details

Review Comment *Made by: (Employee Name)*

RN and LPN had walked patient to bathroom several times. Patient used call light and or they checked in with her and walked her back from bathroom. At the time of this fall, the patient unexpectedly got up unassisted and fell. C/o rib pain, physician notified, no injury confirmed per radiology. The plan of care was updated with communication regarding nature of fall.

Details

Falls

Type of Fall	-To/In bathroom
Injury Type	-Other: *LT RIB DISCOMFORT* -Abrasion/ Laceration/ Bruise
Restraints/Siderails	-Mattress sensor -SR up x2
Physician	-Physician was notified
Was equipment involved?	-No
Mental status at time of fall	-Other: *FORGETFUL* -Alert and oriented x3
Current Documented Risk Assessment Level Prior to this Fall	-High
Could medication have been factor in fall?	-No

Patient Outcomes

Were the healthcare personnel caring for the patient notified?	-Yes
Was additional treatment provided to the patient?	-No
Patient Outcomes	-14 Other: *PAIN LT RIB* -03 Abrasion/Bruise

Severity of Injury

Severity of Injury:	*-MINOR-NO TREATMENT REQUIRED OR MINIMAL TREATMENT (FIRST AID)*

Level 1 Review

Contributing Factors	-N/A
Follow Up Actions	-Additional Data Collection

Level 2 Review

Was the bill adjusted?	-N/A

Level 3 Review

Has a memo been drafted to Medical Staff Leadership?	-N/A

APPENDIX - B

Content Analysis of the Sample Event Incident Reports

Supporting Documentation Provided by Hospitals

Hospitals provided supporting documentation for each of the 40 events reported by staff to an incident reporting system. Of the 40 supporting documents, 19 consisted of full copies of the report forms that hospital staff completed when they reported events to an incident reporting system. We refer to these as incident reporting forms. For the other 21 reported events, hospitals did not provide the full incident report. In these cases, hospitals had not retained the full report but provided archived information to confirm that a report was made. This often included only basic information, such as the event type and date and did not represent the initial incident report. Therefore, we did not include the provided information for these 21 events in our content analysis.

We examined each of the 19 incident report forms and compared them to the Agency for Healthcare Research and Quality (AHRQ) Common Formats.[38, 39] AHRQ did not provide hospitals with the Common Formats until after our sample hospitals reported these events, and even now their use by hospitals is voluntary. However, the Common Formats represent a Federal effort to determine what information hospitals should include in incident reports, and in the absence of Federal requirements for report content, we used the Common Formats as a tool to compare the information in sample hospital incident reports.

Analysis of Data in the Incident Reports

We compared the individual data points in each incident reporting form to specific AHRQ Common Formats data elements. To determine whether an element was present, we reviewed the forms for fields indicating that the hospital requested the information from the reporter and that the request was fulfilled. If the information was requested but not completed (indicated by a blank field), we did not consider the element present. We collapsed the Common Format data elements into three categories based on AHRQ's event reporting forms: basic event

[38] AHRQ, Common Formats. Accessed at https://www.psoppc.org/web/patientsafety on March 31, 2011.

[39] We used AHRQ's Common Formats event reporting tools because they represent AHRQ's efforts to consolidate the necessary elements of an incident report for the purposes of patient safety improvement. AHRQ announced Version 1.0 of the Common Formats in the Federal Register in September 2009 and Version 1.1 in March 2010.

information, patient impact information, and summary and contributing factors.

Results of Content Analysis

In assessing these 19 incident reports, we found that report form and content were largely similar among hospital incident reporting systems. Incident reports most often focused on information that is likely readily available to staff who report, such as when and where the event occurred and the type of event. When compared to the AHRQ Common Formats, most incident reports contained basic event information and patient impact information, but few contained summary information and details about factors contributing to the event. Table B-1 provides a summary of the 19 incident reports listed by the categories and elements suggested in the AHRQ Common Formats.

Table B-1: Common Format Data Elements Present on the Complete Incident Reports (n=19)

Element Description	Number of Reports With Element
Basic Event Information	
Date the event was discovered	19
Location of the event	19
Clinical category of the event	19
Whether the event was an adverse event, near-miss, or unsafe condition	17
Narrative description of the event	16
Patient Impact Information	
Time between event and assessment of harm	16
Whether rescue steps were taken	16
Level of harm caused by event	14
Whether the event prolonged the patient's length of stay	2
Contributing Factor Information	
Whether and which factors contributed to the event	10
Patient safety staff's summary of the event and followup	6
Preventability of the event	6
Whether the event was a National Quality Forum Serious Reportable Event	0
Whether a patient handoff was associated with the event	3

Source: Office of Inspector General analysis of 19 full incident reports associated with reported events.

Basic Event Information. Each of the 19 incident reports included basic event information. The incident reports generally captured and

summarized basic information about the event and the patient involved, including the date, location, and type of event. Most incident reports (17 of 19 reports) also included elements for assessing whether the incident caused patient harm (an actual event) or represented only a near-miss or unsafe condition. To capture this information, reports used a structured format with specific questions and scaled responses, which hospital administrators indicated are useful for initially sorting events. For example, administrators reported that they often review the frequency of particular types of events using preset categories, such as "excessive bleeding" or "surgical-site infection." They reported that more detailed reviews may then be targeted at more frequent events.

Patient Impact Information. Incident reports commonly included descriptions of the impact of the event on the patient and actions taken by staff as a result of the event, such as the time between the event and an assessment (16 of 19 reports) and whether rescue steps were taken (16 of 19 reports). Hospital administrators indicated that patient impact information is often used to prioritize event investigations and, in the case of severe events, trigger special procedures. For example, one administrator said that when staff report events that have caused severe harm, alerts are sent automatically to specially trained response staff.

Contributing Factor Information. Incident reports were not likely to contain analytic information included in the Common Formats, such as factors that contributed to the event (10 of 19 reports). A number of hospital administrators indicated that this is the most useful information for conducting patient safety activities because it enables them to understand whether particular contributing factors, such as confusing medication labels, are a common cause of multiple types of events.

Estimates, Confidence Intervals, and Key Statistics

We computed incidence rates and corresponding 95-percent confidence intervals using appropriate statistical methods based on the sample.

Table C-1: Estimates and Confidence Intervals

Events and Reasons Events Were Not Reported	Percentage Estimate	95-Percent Confidence Interval	
		Lower Bound	Upper Bound
Reporting Rate of Adverse and Temporary Harm Events (n=293)			
Events not captured	86.4%	81.6%	90.0%
Events captured	13.7%	10.0%	18.4%
Commonly reported to incident reporting system	24.6%	19.0%	31.2%
Not commonly reported to incident reporting system	61.8%	55.4%	67.8%
Not caused by a perceptible error	12.0%	8.5%	16.5%
Was an expected outcome or side effect	11.6%	8.3%	16.0%
Caused little harm and/or harm was ameliorated	10.6%	7.4%	14.9%
Was not on hospital's mandatory reporting list	8.5%	5.5%	12.9%
Occurs frequently in hospitals	7.9%	5.2%	11.6%
Symptoms became apparent after discharge	5.1%	2.8%	9.1%
Occurred in patient with a history of similar events	3.8%	2.1%	6.7%
Administrator did not provide a reason*	2.4%	1.2%	4.9%
Events captured and events commonly reported to incident reporting systems	38.2%	32.2%	44.6%
Reporting Rate of Adverse Events (n=124)			
Captured adverse events	12.9%	8.3%	19.6%
Reporting Rate of Temporary Harm Events (n=169)			
Captured temporary harm events	14.2%	9.4%	20.8%

*Given the small proportions, confidence intervals for projected numbers exceed 50-percent relative precision.
Source: Office of Inspector General (OIG) analysis of surveys associated with the 293 events identified by OIG.

Figure C-1: Statistical Test Results

Statistical Test	P-Value for Difference in Proportions
Test for relationship among harm events (i.e., adverse event or temporary harm event) and whether incident reporting systems captured the events	0.7380

Note: Weighted chi-square and Cochran-Mantel-Haenszel chi-square produced similar results.
Source: OIG analysis of surveys associated with the 293 events identified by OIG.

APPENDIX - D

Rates of Reporting by Event Category

Table D-1 contains information about the rate of reporting for events identified in the sample by type of event.

Table D-1: Rates of Reporting by Event Category (n=293)

Type of Event	Number of Sample Events	Number of Captured Events	Percentage of Captured Events
Events Related to Medication	**111**	**14**	**13%**
Acute renal insufficiency (kidney failure)	6	0	0%
Allergic reaction or side effect related to skin	6	0	0%
Allergic reaction to blood or related product	2	1	50%
Delirium or change in mental status	29	7	24%
Dysrhythmia	3	0	0%
Excessive bleeding	15	2	13%
Gastrointestinal complication	4	0	0%
Hypoglycemic event	17	2	12%
Hypotension	5	1	20%
Other events related to medication	2	0	0%
Respiratory complication	6	1	17%
Severe allergic reaction	3	0	0%
Severe headache or dizziness	3	0	0%
Severe hypotension	4	0	0%
Thrush and other opportunistic infection	6	0	0%
Events Related to Patient Care	**95**	**15**	**16%**
Aspiration	11	1	9%
Deep vein thrombosis, pulmonary embolism	5	0	0%
Exacerbation of preexisting medical condition	4	0	0%
Failure to treat constipation or obstipation	3	0	0%
Intravenous infiltrate with symptoms	5	1	20%
Intravenous volume overload	24	0	0%
Other events related to patient care	5	2	40%
Patient fall with injury	5	5	100%
Skin tear, laceration, abrasion, or other breakdown	9	1	11%
Stage I, Stage II, or unstaged pressure ulcer	19	5	26%
Stage III pressure ulcer	3	0	0%
Tachycardia or dysrhythmia	2	0	0%

continued on next page

Table D-1: Rates of Reporting by Event Category (n=293) (Continued)

Type of Event	Number of Sample Events	Number of Captured Events	Percentage of Captured Events
Events Related to Surgery or Other Procedures	62	7	11%
Acute coronary syndrome	1	0	0%
Blood clot and other occlusion	2	0	0%
Cardiac complication	6	2	33%
Excessive bleeding	11	1	9%
Iatrogenic pneumothorax	3	1	33%
Other events related to surgery or other procedures	5	0	0%
Postoperative ileus	3	0	0%
Postoperative or postprocedural hypotension	2	0	0%
Postoperative urinary retention	3	0	0%
Prolonged nausea and vomiting	2	0	0%
Respiratory complication	6	2	33%
Severe hypotension	4	1	25%
Surgical tear or laceration	3	0	0%
Urinary catheter-associated trauma	3	0	0%
Urinary retention	8	0	0%
Events Related to Infection	25	4	16%
Bacterial infection	1	0	0%
Other bloodstream infection	4	1	25%
Respiratory infection	5	1	20%
Surgical or procedural site infection	4	1	25%
Urinary tract infection	6	0	0%
Vascular catheter-associated infection (central or peripheral line)	5	1	20%

Source: Office of Inspector General (OIG) analysis of incident reports associated with the 293 events identified by OIG.

Agency Comments

Agency for Healthcare Research and Quality

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

540 Gaither Road
Rockville, MD 20850
www.ahrq.gov

NOV 16 2011

TO: Inspector General, Department of Health and Human Services

FROM: Director

SUBJECT: OEI Inspection Number OEI-06-09-00091

Thank you for the opportunity to review and comment on the Office of Inspector General's draft report entitled, OEI-06-09-00091, *Hospital Incident Reporting Systems Do Not Capture Most Patient Harm.*

Recommendation: ***AHRQ and CMS should collaborate to create a list of potentially reportable events and provide technical assistance to hospitals using the list.***
AHRQ concurs with this recommendation. AHRQ has begun meeting with CMS to explore the role of the Common Formats as the foundation for a list of reportable events.

Recommendation: ***CMS should provide guidance to accreditors regarding surveyor assessment of hospital efforts to track and analyze events, and should scrutinize survey processes when approving accreditation programs.***
AHRQ concurs with this recommendation. AHRQ will meet with CMS staff to continue collaboration on the potential use of Common Formats with surveyors and hospital adverse event reporting systems.

Other technical notes for OIG staff:
Page 5—last sentence - The Common Formats' three event reporting forms focus on specific areas: information describing the event, information describing the patient, and summary and contributing factors.

We suggest adding a new sentence: "The Common Formats also contain event specific modules that provide additional detail for high volume or high harm events."

If you or your staff have any questions, please feel free to contact Dr. Bill Munier, Director, Center for Quality Improvement and Patient Safety at William.munier@ahrq.hhs.gov or 301-427-1921.

/S/

Carolyn M. Clancy

Centers for Medicare & Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: NOV 18 2011

TO: Daniel R. Levinson
Inspector General

/S/

FROM: Donald M. Berwick, M.D.
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Hospital Incident Reporting Systems Do Not Capture Most Patient Harm (OEI-06-09-00091)

Thank you for the opportunity to review and comment on this very timely and important study. In the subject report, the OIG examines whether hospitals identified adverse events on their own and, if so, the types of follow-up actions they took. The OIG reviewed the characteristics of hospitals' internal incident reporting systems, as well as the methods used by hospital accrediting organizations in evaluating hospital safety practices. There is a significant opportunity for far-reaching improvement in the experience of individuals and families in the United States health care system and the patient safety arena, as well as, an opportunity for savings to the taxpayer and the beneficiary.

We note that since the incidents reviewed in this report, the Department of Health and Human Services (HHS) has launched a new and ambitious public-private partnership entitled the "Partnership for Patients." This national Partnership will help improve the quality, safety and affordability of health care for Medicare, Medicaid and CHIP beneficiaries, and for all Americans. More than 6,200 organizations – including more than 2,800 hospitals – have signed the Partnership Pledge.

HHS and the Centers for Medicare & Medicaid Services (CMS) are working with a wide variety of public and private partners to achieve the two core goals of this Partnership:

- Keeping patients from getting injured or sicker in the health care system, and
- Helping patients heal without complication by improving transitions from acute-care hospitals to other care settings, such as home or a skilled nursing facility.

Hospitals' ability to identify patient harm that has occurred is an essential component of their efforts to prevent future such harm. We are very appreciative of the contribution that the OIG is making to our knowledge of common hospital approaches to identifying harm, the limitations of the existing methods employed, and the OIG's recommendations for improvement. The recommendations in this OIG report will help us strengthen the Partnership for Patients initiative as we work with hospitals and other health care providers to improve patient safety.

Centers for Medicare & Medicaid Services (continued)

Many of the hospital administrators contacted for the OIG's report indicated that they use multiple adverse event detection methods, including medical record reviews, administrative data screening, reviews for evidence of healthcare-associated infections, and post-procedure checklists. We expect all hospitals to use multiple methods to detect patient harm that has occurred. At the same time, we recognize that the detailed physician case record reviews, such as the OIG employed in its November 2010 report to estimate the incidence of harm to Medicare beneficiaries, are labor-intensive and costly, even when use is made of trigger tools and other preliminary screening to narrow the number of records to be reviewed. As a result, these more comprehensive methods are likely to remain comparatively limited in their scope.

As the OIG's report indicates, internal hospital incident reporting systems have limitations that result in significant underreporting of adverse patient events. Since hospital administrators reported to the OIG that incident reporting systems continue to be their primary method to identify adverse events, the limitations in such systems are particularly important. We fully agree with the OIG on the need to strengthen hospital incident reporting systems.

OIG Recommendation

The Agency for Healthcare Research and Quality (AHRQ) and CMS should collaborate to create a list of potentially reportable events and provide technical assistance to hospitals in using the list.

CMS Response

The CMS fully concurs with this recommendation and have initiated communications to carry out the desired collaboration. Further, once such a list is developed we will explore methods to promote its use by hospitals and to educate their staff. We also agree that the list could be used to educate State and accreditation organization surveyors. While hospitals are not required under the existing Medicare health and safety regulations to use CMS-developed lists of adverse events, such a list can be highly beneficial in improving current incident reporting systems.

We also note the OIG observation that the purpose of this list would not be to support any external reporting, but rather to educate hospital staff about the full range of harm that occurs in hospitals and to clarify for staff those events or circumstances which should be reported internally. We concur that the purpose of such lists should not include creating any new external adverse event reporting requirements, particularly since there are a number of States that have already put external reporting systems in place.

OIG Recommendation

CMS should provide guidance to accreditors for assessment of hospital efforts to track and analyze events, and should scrutinize survey processes when approving accreditation programs.

Centers for Medicare & Medicaid Services (continued)

Page 3 – Daniel R. Levinson

CMS Response

We concur with this recommendation. As the OIG states in its report, we are developing draft surveyor guidance for the hospital quality assessment and performance improvement (QAPI) requirement that currently exists as a Medicare Condition of Participation. We are also pre-testing a surveyor worksheet to assist surveyors in determining compliance with the QAPI Condition. We anticipate releasing official CMS guidance on assessing QAPI compliance in the near future. We will incorporate into that guidance our expectation that hospitals improve their internal incident reporting systems by providing hospital staff with detailed, unambiguous instructions on the types of events that should be reported. We will suggest that hospitals start with the AHRQ Common Formats in developing these instructions.

Once we issue final, formal guidance for surveyors on assessing QAPI compliance, and incorporate that guidance into standard operating procedures, the three national accreditation organizations with CMS-approved Medicare hospital accreditation programs will be required to review that guidance and ensure that their survey process is consistent with it.

At such time as CMS and AHRQ develop lists in response to the OIG's first recommendation, we will amend our guidance to make reference to these lists as an available tool to assist hospitals in instructing staff.

Thank you for your attention to this key area of health care and for specific ideas on methods by which our oversight of hospitals may be improved.

ACKNOWLEDGMENTS

This report was prepared under the direction of Kevin K. Golladay, Regional Inspector General for Evaluation and Inspections in the Dallas regional office; A. Blaine Collins, Deputy Regional Inspector General; and Ruth Ann Dorrill, Deputy Regional Inspector General.

Jeremy Moore served as the lead analyst for this study. Other principal Office of Evaluation and Inspections staff from the Dallas regional office who contributed to the report include Amy Ashcraft and Maria Balderas; central office staff who contributed include Rob Gibbons, Sandy Khoury, Tasha Trusty, and Rita Wurm.

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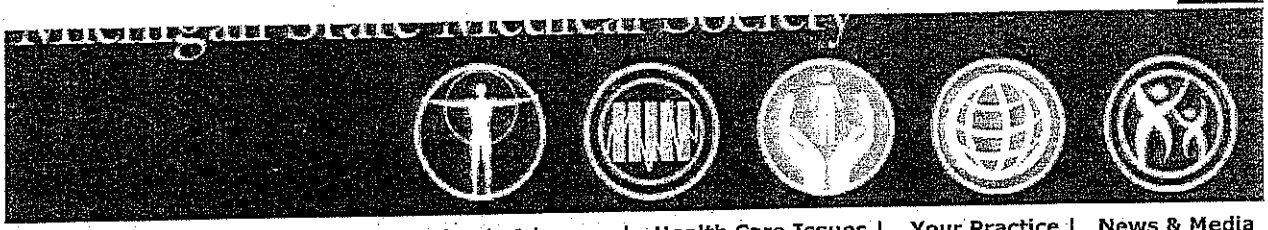

"Patients First" Reform Package:

Studies project that by 2020 the state of Michigan will have a physician shortage of over 4,500 doctors in fields like ***pediatrics, family practice and general and internal medicine****. What's more, many of Michigan's cities and urban areas with the largest populations are at risk of becoming underserved.*

As our state struggles to attract and retain high quality physicians to meet the growing health needs seniors, children and families, **common sense tort reform legislation that puts patients first** has the ability to *make Michigan a much more appealing state in which to start a practice and see patients and strengthening and restoring Michigan's tort climate*.

The ***Patients First Reform Package*** would:

- **Better define "economic" damages"**—This reform would clarify Michigan law when it comes to what constitutes "economic" damages (like lost wages and legal bills) and "non-economic" damages (like pain and suffering).
- **Hold physicians to the same standards as trial lawyers**—Physicians will be held to the same negligence standards that attorneys are, leveling the playing field.
- **Close a confusing legal loophole that allows unnecessary suits**—Removing the "Loss of Opportunity" doctrine would clear up ambiguous statues that cloud the judicial waters, a solution Michigan Justices have been asking for.
- **Prevent trial lawyers from artificially inflating awards**– End the practice of using compound interest in the collection of damages when multiple parties are named in a lawsuit.
- **Protect patients by bringing more professionals under medical malpractice guidelines**—Unlicensed health care professionals (like X-Ray techs) will be brought under medical malpractice guidelines to protect patients.
- **Prevent trial lawyers from using a loop hole into default judgments against physicians**—By reforming guidelines that cover the timely filing of legal documents trial lawyers will no longer be allowed to win default judgments against physicians by failing to notify them that they are being sued.
- **Close a loophole that doubles the statute of limitations**—Ends the practice of trial lawyers who use a loophole in the law to double the statute of limitations for filing wrongful death suits.
- **Put patients first, not their lawyers**—Right now, trial lawyers are collecting interest payments on expenses they have not incurred. Ending this deceptive practice will ensure timely representation and that patients benefit most from judgments, not their lawyers

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Medical Tort: Ranking the 50 States

By John R. Graham

Key Points:

- States' liability laws drive medical-tort costs, which increase health costs.
- Evidence indicates that medical-tort costs are higher than optimal, with consequences including unfair verdicts, reduced availability of doctors, and increased use of wasteful "defensive" medicine.
- Eight variables contribute to a medical-tort index that measures all 50 states' success at reforming medical-tort laws to mitigate these problems, and provides a partial update to the 2009 *U.S. Index of Health Ownership*.
- Mississippi, Nevada, Michigan, Colorado, and Louisiana have been most successful at reforming medical tort; the least successful include Vermont, Rhode Island, Kentucky, Pennsylvania, and Iowa.

For three years, 2007 through 2009, PRI published the *U.S. Index of Health Ownership*.[1] The *Index* continues to be the only effort to measure the degree to which individuals, whether patients, health professionals, entrepreneurs, or taxpayers, "own" the health care in their states. It quantifies how state laws and regulations affect the liberty of citizens involved in state government health plans (primarily Medicaid), the private health insurance market, and the provision of medical services, as well as the effect of medical tort on people's freedom to engage health services.

Although there will not be a new edition for 2010, new research allows an update of one of the four categories of health ownership: medical tort. Lawrence J. McQuillan and Hovannes Abramyan have recently completed a 2010 edition of the *U.S. Tort Liability Index*, which has a number of measurements included in the *U.S. Index of Health Ownership*. The latest edition of the *U.S. Tort Liability Index* includes 42 variables.[2]

Thirteen of these measure outputs, and 29 measure inputs. McQuillan and Abramyan rank the states by taking a simple average of each type of measurement (but they do not publish a ranking that includes all 42 measurements). Alaska, Hawaii, and North Carolina perform best according to the ranking of outputs, whereas Oklahoma, Texas, and Ohio bested the ranking of inputs.

Eight of the measurements in the *U.S. Tort Liability Index* are relevant to the *U.S Index of Health*

Ownership: one output and seven inputs. The previous edition of the *U.S Index of Health Ownership* included six measurements of medical tort, but McQuillan and Abramyan have discovered more variables for their 2010 edition of the *Tort Liability Index*, allowing more detailed measurement.

Reducing the burden of medical tort is critical to increasing Americans' health ownership and reducing medical costs that curtail our access to care. Some progress is evident, but states aiming to improve their medical-tort laws still have a long way to go.

As a partial update of the *U.S. Index of Health Ownership*, this *Health Policy Prescription* calculates a medical-tort index from a simple average of the eight relevant variables:

1. The ratio of medical-malpractice insurance losses per projected personal health expenditures in 2008. The data come from A.M. Best Company and the Centers for Medicare and Medicaid Services.
2. Caps on non-economic-damage awards in medical-malpractice lawsuits. This tracks whether a state has limits on non-economic damages or has increased the negligence standard required for medical malpractice. For example, North Dakota has a $500,000 limit. McQuillan and Abramyan cite evidence that capping non-economic damages reduces defensive medicine.
3. Caps on punitive-damage awards in medical-malpractice lawsuits. For example, Washington does not allow punitive damages, and Alaska limits them to $500,000 or three times compensatory damages. McQuillan and Abramyan cite evidence that capping punitive damages lowers medical-malpractice premiums.
4. Attorney-fee limits for medical-malpractice cases. New York, for example, uses a sliding scale: Lawyers can take 30 percent of the first $250,000 of an award, 25 percent of the next $250,000, 20 percent for the next $500,000, 15 percent of the next $250,000, and 10 percent above $1.25 million. McQuillan and Abramyan cite evidence that such limits increase the supply of physicians in a state.
5. Pre-trial screening or arbitration in medical-malpractice cases. Pre-trial screenings determine the validity of a case, while arbitration is an alternative to trial. Nebraska, for example, mandates review of medical-malpractice claims by a panel before proceeding to trial. Oregon mandates dispute resolution within 270 days of filing an action, unless both parties waive mediation or arbitration. McQuillan and Abramyan cite evidence that these opportunities reduce the number of meritless cases.
6. Does the state allow a "Food and Drug Administration (FDA) defense" or a "Federal Trade Commission (FTC) defense"? These defenses allow some immunity if the FDA has approved the therapeutic product or the FTC has approved its advertising. For example, West Virginia holds that health providers are not liable for personal injuries caused by an FDA-approved drug. These rules reduce the burden of over-regulation which limits investment by pharmaceutical and medical-device makers.
7. Conditions on the use of expert witnesses in medical-malpractice lawsuits. For example, Minnesota requires that medical-malpractice claimants sign an affidavit if they have consulted with an "expert." Michigan requires "experts" to be licensed and board-certified in the same specialty as the defendant, and that they be engaged in active practice or actually teaching medicine. These rules increase the likelihood of fair verdicts.

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8. Statute of limitations on medical-malpractice cases. Kentucky, for example, sets its statute of limitations at one year from the alleged act or reasonable discovery, but no more than five years after the act. McQuillan and Abramyan cite evidence that such rules lower medical costs.

Although other variables included by McQuillan and Abramyan also influence health ownership, these eight are specific to health care alone. Therefore, they comprise the update to the medical-tort component of the *U.S. Index of Health Ownership*. Table 1 shows the results. Mississippi, Nevada, Michigan, Colorado, and Louisiana lead the pack; while Vermont, Rhode Island, Kentucky, Pennsylvania, and Iowa bring up the rear. Even the leaders, however, lag in some measurements.

Mississippi, for example, leads on procedural rules: Pre-trial screening or arbitration and conditions on the use of expert witnesses. However, it does not limit lawyers' ability to abuse their privilege by limiting their share of awards. Colorado and Louisiana also fail to impose limits. Unfortunately, the laggards do not show a similar pattern: The bottom five states perform poorly in all eight measurements.

Reducing the burden of medical tort is critical to increasing Americans' health ownership and reducing medical costs that curtail our access to care. Some progress is evident, but states aiming to improve their medical-tort laws still have a long way to go.

2010 Medical-Tort Index	
State	Medical Tort Rank
Mississippi	1
Nevada	2
Michigan	3
Colorado	4
Louisiana	5
Texas	6
Florida	7
Illinois	8
Oklahoma	9
Kansas	10
California	11
Alaska	12
Montana	13
Idaho	14
West Virginia	15
Massachusetts	16
New Hampshire	17
Nebraska	18
Indiana	19
North Dakota	20
Ohio	21
Arkansas	22
Arizona	23
Georgia	24
Delaware	25
Tennessee	26
Virginia	27
Utah	28
Missouri	29
New Jersey	30
North Carolina	31
Washington	32
Alabama	33
Minnesota	34
Wisconsin	35
South Dakota	36
South Carolina	37
Connecticut	38
Oregon	39
Maine	40
Maryland	41
New Mexico	42
New York	43
Wyoming	44
Hawaii	45
Iowa	46
Pennsylvania	47
Kentucky	48
Rhode Island	49
Vermont	50

Endnotes

1 John R. Graham, *U.S. Index of Health Ownership*, 3rd edition (San Francisco: Pacific Research Institute, 2009).

2 Lawrence J. McQuillan and Hovannes Abramyan, *U.S. Tort Liability Index: 2010 Report* (San Francisco: Pacific Research Institute, 2010).

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Center for America

Updates About State Legal Reform

Nov 20, 2007

Special Alert:

MSMS
The Voice of 15,000 Michigan Physicians

Liability Rate Drop Shows Tort Reform is Working

FOR IMMEDIATE RELEASE:
November 20, 2007

Contact:
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East Lansing, Mich. – A clear indication that Michigan's 1993 tort reforms are working is that the state's largest physician medical malpractice insurer is cutting its premiums by 12 to 25 percent for Wayne County physicians, Michigan State Medical Society announced today.

The average decrease for all physicians in Wayne County will be 13 percent beginning January 1, according to American Physicians Assurance Corporation, a medical liability insurer based in East Lansing that is a wholly-owned subsidiary of the publicly held American Physicians Capital, Inc. (APCapital).

Statewide, American Physicians' malpractice insurance rates will be reduced by an average of 6.5 percent in 2008.

"Michigan's carefully designed tort reforms do not deny a truly injured patient from just compensation," said Sophie J. Womack, MD, a Detroit neonatalogist who serves as president of the Wayne County Medical Society of Southeast Michigan and as a member of the MSMS board of directors. "The reforms have helped reduce the 'lottery mentality' of each mal-occurrence, or bad outcome, from becoming a lawsuit."

"Let me put this in perspective," said Robert J. Jackson, MD, an Allen Park family physician and a member of the American Physicians Advisory Board. "Rates for my specialty, family practice, will go down 14 percent. Nothing in the overhead costs of my practice is going down, except, unbelievably, the cost of my malpractice insurance.

"If this isn't evidence that Michigan's tort reforms are working, I don't know what is," Doctor Jackson said.

Doctor Jackson said that obstetricians will see a 14 percent reduction and orthopedic surgeons will see a 25 percent reduction.

"Even neurosurgeons, who perform very high risk procedures, will see a 12 percent cut," Doctor Jackson said.

Since the tort reforms went into effect in 1994, each component of the legislation has withstood constitutional challenges from the trial bar, according to Doctor Womack. Unfortunately, tort reforms in Illinois were overturned on November 13, prompting the Illinois State Medical Society to issue a news release stating that the "verdict could derail health care access."

"Over the past 13 years, the Michigan Supreme Court has supported the obvious intent of Michigan legislators to improve the medical liability climate in our state so that their constituents, our patients, will be able to have access to the physicians they want and need," Doctor Womack said.

Previously, many physicians who practiced in high-risk specialties such as obstetrics, neurosurgery, and orthopedic surgery often left Michigan for states where lawsuits were not as frequent and jury awards were not as high.

"The news about medical malpractice rates announced today certainly is good news for our efforts at the Michigan Health Council," said MHC vice president Susan Sanford, who heads a program called "Practice Michigan." "We believe that improvements to Michigan's practice environment will directly correlate to our success in recruiting and retaining physicians here."

Michigan is a more favorable place to practice than many neighboring states, Doctor Jackson said.

He said a neurosurgeon practicing today in Detroit pays a manual rate of $201,512 for a $1 million/ $3 million policy, while a colleague in Chicago, where tort reform was just overturned, pays $256,404 – a difference of $54,892.

As part of the 1993 tort reforms, the licensing fee that physicians pay to the state was tripled. The extra money was earmarked for the Attorney General's office to conduct investigations of patient complaints against physicians.

During this same time period, roughly the past two decades, a nationwide movement also has been underway focusing on risk management education for physicians and their practices, as well as on patient safety and quality initiatives throughout the U.S. health care system.

"The bottom line is that all of these efforts have improved patient access to health care by limiting the exposure to unjustified lawsuits. They also have improved the overall health care system," Doctor Jackson said.

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The mission of the Michigan State Medical Society is to promote a health care environment that supports physicians in caring for and enhancing the health of Michigan citizens through science, quality, and ethics in the practice of medicine. To learn more, visit **www.msms.org**

House Passes PATH Act Medical Malpractice Tort Reforms

Posted on March 27, 2012 by Mike Matray

On March 22, the United States House of Representatives voted 223-181 to pass House Resolution 5 (HR 5), the Protecting Access to Healthcare (PATH) Act, which would repeal the Independent Payment Advisory Board (IPAB) for Medicare as well as place a federal $250,000 cap on non-economic damages in medical malpractice lawsuits, limit punitive damages, establish a three-year statute of limitations and abolish joint and several liability.

The portions of HR 5 that affect medical malpractice liability has been debated several times since Republicans took control of the House of Representatives in 2010, but previous versions were not attached to the IPAB repeal. The portions of the PATH Act that deal with medical malpractice liability were debated last year as the Help, Efficient, and Accessible, Low-cost, Timely Health Care (HEALTH) Act.

What is interesting about the federal medical malpractice tort reforms is that it catches conservatives in a Catch-22. Republicans love tort reform and they love legislation that protects physicians from meritless lawsuits, but they also love to use the 10th Amendment to the United States Constitution as their argument for a smaller, more limited federal government. The 10th Amendment states "the powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively."

Viewed in the context of the 10th Amendment, a federal cap on non-economic damages violates individual states' rights to regulate medical malpractice litigation as their legislatures see fit.

As evidence of conservative concern over what they deem an unconstitutional overreach by Congress into tort law, an issue not enumerated for the federal government in the Constitution, one need look no further than the conservative think tank the Heritage Foundation, which has come out against the PATH Act and did the same against the HEALTH Act last year. This time, the conservative National Conference of State Legislators as well as Tea Party Nation founder Judson Phillips has joined the Heritage Foundation in their protest.

Conservatives aside, physician groups very much support HR 5, saying that a federal cap on non-economic damages would add predictability to medical malpractice liability lawsuits, which would have a deflating effect on their medical malpractice insurance premiums.

This entry was posted in federal tort reform, HEALTH Act, non-economic damage cap, PATH Act, Tort Reform. Bookmark the permalink.

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Recent Studies and Reports on Physician Shortages in the US

May 2011

Center for Workforce Studies
Association of American Medical Colleges

Association of
American Medical Colleges

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Recent Studies and Reports on Physician Shortages in the U.S.

Over the past several years, a growing number of national, state and specialty specific studies have concluded that the US physician workforce is facing current or future shortages. This report presents a summary of these recent studies. The report is divided into three sections: 1) a summary of 33 state reports on physician shortages; 2) a summary of 22 specialty shortage reports; and 3) a summary of 6 national studies on the physician workforce.

STATE REPORTS

Since 2002, at least 33 states have assessed their current or future physician workforce needs. In general, the underserved and elderly populations are most likely to be affected. Additionally, many of the state reports point out shortages in specialties that are featured in the specialty report section, including allergy and immunology, cardiology, child psychiatry, dermatology, endocrinology, neurosurgery, primary care, and psychiatry.

Alaska (2006) - "Competition for Physicians will Intensify"

According to a report by the Alaska Physician Supply Task Force, Alaska has a severe shortage of physicians and is far behind other states in production capacity. Up to 16% of rural physician positions in Alaska were vacant in 2004. There are currently 205 physicians (MDs and DOs) providing patient care per 100,000 residents compared to the national average of 238 for the same population. According to the Task Force projections, Alaska needs a net gain of 59 new physicians a year to offset the annual loss of 40 per year due to retirement or migration out of the state. Some strategies for securing an adequate physician supply for Alaska's needs include increasing the number of state-subsidized medical school seats, increasing the number of residency positions in Alaska, and expanding loan repayment assistance programs for physicians practicing in Alaska.[1]

Arizona (2005) – "Still Far Below the National Average"

The 2005 Arizona Physician Workforce Study, prepared by the Arizona State University and University of Arizona Health Sciences Center, concludes that while the growth in the physician workforce over the past decade outpaced the increase in population, a number of specialties have decreased in numbers, including allergists, cardiovascular surgeons, endocrinologists, gastroenterologists, hematologists, and infectious disease specialists. Arizona's high projected population growth combined with the limited number of in-state medical education and training opportunities will make Arizona increasingly reliant on recruiting physicians from other states at a time of projected national shortages.[2]

California (2009) – "Likely to Face Physician Shortage in 2015"

The California HealthCare Foundation, in a 2009 report, states that the overall supply of physicians in the state is lower than earlier estimates. Rural counties have fewer physicians per capita than their urban counterparts and also face the additional burden of an aging physician workforce coupled with difficulty recruiting younger replacements. Moreover, the state has a diminishing supply of primary care physicians but an abundance of specialists. For example, only 34% of active physician reported practicing primary care and only 16 of California's 58 counties are within the range of 60-80 primary care physicians per 100,000 population and in 8 counties the number is less than half the recommended amount. Of all active physicians in the state 67% reported being non-primary care physicians and the number of specialists per 100,000 is 115 in California, well above the target range of 85-105.

The University of California Office of Health Affairs and University of California Health Sciences Committee commissioned a report on California's physician workforce conducted by the University of Albany's Center for Health Workforce Studies. The population of California is growing rapidly which will place great strains on the healthcare delivery system and the physician workforce. More than one-fourth of the state's practicing physicians were over age 55 in 2000. In addition, the state has a mal-distribution of physicians with 60% of the current physicians practicing in only five counties.[3] In partial response to this report, in 2006, the California Board of Regents approved the establishment of a new medical school at the University of California at Riverside.[4]

California (2008) – "Minorities Underrepresented in California Physician Workforce"

A report by the Center for California Health Workforce Studies at the University of California, San Francisco shows that both black and Latino physicians are underrepresented in the workforce. In California, 40% of the population is black or Latino but less than 10% of the physicians in the state are. The state has a population of 35 million people and only 2,000 black physicians and 3,000 Latino physicians are currently practicing. This lack of diversity hurts access to care in underserved areas since minority physicians play a crucial role in serving these areas with 40% of ethnic physicians working in primary care.[5]

Colorado (2007) – "Serious Implications for Access to Primary Health Care"

The Colorado Health Institute with funding from the Colorado Trust released a report detailing the aging physician workforce in Colorado as the main impetus for the shortage of physicians in the state. 35% of physicians who responded to a 2005 survey were 55 years of age or older just as the elderly population in Colorado is expected to increase by 50% by 2020; a segment of the population that generally uses more health care services. Additionally, maldistribution continues to be a problem in Colorado with only 11% of physicians practicing in rural areas and 15% of the population living there.[6]

Florida (2008) – "Impending Physician Shortage in the State"

In 2007 the Florida legislature directed the Florida Department of Health to undertake a comprehensive evaluation of Florida's physician workforce and its impact on accessing quality care in the state. One of the report's recommendations for offsetting the physician shortage is to pursue a policy of creating and expanding medical residency positions in Florida. They also note that the physician workforce in Florida is predominantly white (66.57%) and male (77%) which is not representative of the population. An earlier 2005 report by the Board of Governors of the State University System of Florida, notes, "though data sources are conflicting on the exact number of physicians that will be needed, all agree demand outstrips production." A quarter of Florida's practicing physicians are over 65 and only 10% are under 35. Florida's population is projected to increase 60% by 2030 and the aged population is projected to grow by 124% in the same span which will dramatically increase demand for physician services. [i] In 2006, the Florida Board of Governors approved the establishment of two new medical schools, University of Central Florida (UCF) and the Florida International University (FIU). Both schools opened for their inaugural classes in the fall of 2009 with 41 and 43 students respectively.[7] [8]

Georgia (2008) – "Georgia's Drought of Physicians Will Become a Crisis"

Georgia has fallen far behind in training physicians and is now scrambling to make up for the deficit said a study commissioned by the Medical College of Georgia. Without immediate statewide cooperation in expanding medical education and residency programs, the state may never again have an adequate supply of physicians. For too long Georgia has relied on out of state and international physicians to make up for the lack of Georgia trained doctors. Without changes in the state's medical

education system, Georgia will rank last in the United States in physicians per capita by 2020. The study suggests increasing Medical College of Georgia's class size from 190 currently to 240 by 2017 making it one of the largest classes in the country. Furthermore, the Medical College of Georgia is advised to open a new campus in Athens in association with the University of Georgia and develop regional campuses for 3rd and 4th year students across the state.[9] An earlier study, conducted in 2006, showed that only 50% of the graduates with confirmed practice plans are remaining in the state, down from 56% in 2002.[10]

Hawaii (2005) - "Disproportionate Distribution Leaves Rural Areas Lacking"

A health workforce assessment of Hawaii's physicians was published in the Californian Journal of Health Promotion outlining the complex issues of maldistibution of physicians in Hawaii. The Islands of Maui, Kauai, Lanai, Molokai, and Hawaii are federally designated shortage areas making health care difficult to obtain. However, the state as a whole maintains a higher than average physician to population ratio with 19 more physicians and 15 more primary care physicians than the national average. These statistics mask the fact that the rural areas are suffering from a small workforce as the physician to population ratio does not take location and distribution into account at a sub-state level. A physician workforce database is underway to serve as a tool for planning for future need.[11]

Idaho (2007) - "Need for more Physicians in Idaho"

In order for Idahoans to have access to physician services the State needs to provide reasonable student access to medical education says a study requested by the Idaho Board of Education. Idaho ranks 49th among the 50 states (50th if the District of Columbia is considered) on the total number of physicians in the state with 198 per 100,000 population which is 66 percent of the national average. The physician shortage is likely to become more acute due to an aging workforce. Using data from the American Medical Association, it was determined that 40 percent of Idaho's physicians are age 55 or older and that 21 percent are 65 or older. This shows Idaho has the 6th oldest physician workforce in the country. To complicate the shortage further, the reports suggest that the population of Idaho is expected to increase and was ranked 8th in growth rate between 1970 and 2000. To resolve the physician shortage, Idaho is looking for ways to expand medical education in the state. Without a medical school in Idaho, the state relies on and subsidizes 18 WWAMI seats and 8 Utah seats. With only 1.82 first-year medical school seats per 100,000 population, Idaho ranks 48th in the nation and the state is looking for new ways to open doors to medical education for Idaho students.[12]

Illinois (2010) - "One-half of Graduating Illinois Residents and Fellows are Leaving"

A 2010 Illinois Physician Workforce report by Northwestern University's Fienberg School of Medicine, the Illinois Hospital Association, and Illinois State Medical Society describes Illinois as "in danger of being unable to meet even the most pressing healthcare needs." The report describes the many causes of the Illinois physician shortage with one reason being that one-half of residents and fellows who graduate end up leaving the state to practice. The reason for the low retention rate is that Illinois has a reputation for not being physician friendly due to its medical liability procedures and high malpractice insurance rates. Aside from the flight of Illinois graduates, the rural areas of the state are suffering from a lack of physicians and only 1.5% of residents indicated that they planned to practice in a rural setting. In 2010, the Illinois assembly passed legislation to create an Illinois Workforce Institute to collect, analyze, and distribution information of the state's physician workforce.[13]

Indiana (2007) – "Projections Indicate that Shortages Will Continue to Worsen"

In a brief written by the University Of Indiana School Of Medicine's Department of Family Medicine severe shortages of several health professions, especially primary care physicians, have been documented. Currently the state is lacking at least 5,000 physicians, out of which 1,000 need to be primary care physicians, to appropriately care for the population. This number will grow by 2020 to 2,000 additional primary care physicians. Furthermore, a mere 19% of urban counties and only 2% of rural counties in Indiana are at the target for population to physician ratios when considering the number of primary care physicians. These already severe shortages are going to become even more prevalent when considering that the number of Indiana residents over age 65 will double between 2000 and 2030, the segment of the population that uses health care services the most.[14]

Iowa (2007) – "Aging Population will Alter Demand for Physician Services"

After reviewing physician supply and demand data, a task force established by University of Iowa Health Care leaders developed a set of recommendations for improving the physician supply that focused on modest increases in physician education and training capacity as well as a detailed set of recruitment and retention strategies. The five specialties perceived to be in greatest need were psychiatry, neurosurgery, general internal medicine, orthopedic surgery, and cardiology.[15]

Kentucky (2007) – "Demand for Physicians Expected to Increase"

For decades Kentucky has been plagued by a shortage of physicians, especially in rural areas says a report by the Kentucky Institute of Medicine. Almost half of Kentucky's counties-55 out of 120, and most of them rural-are officially designated Health Professional Shortage areas (HPSA) for primary care. Aside from the overall shortage of physicians, 400 of all the family physicians in Kentucky, are age 60 or above and are nearing retirement. Kentucky's physicians are not well distributed which is evidenced by the fact that, "more than 43% of the State's 4.2 million residents live in rural areas, but only 28% of its physicians do." Furthermore, high rates of chronic diseases at far greater rates than the national average might necessitate additional physicians beyond those already needed, to serve the State. To address the projected shortage the report recommends increasing the applicant pool, increasing medical school class size, and developing regional clinical medical school campuses, among other strategies.[16] A study conducted in 2005 confirmed many of the same findings in the 2007 study.[17]

Maryland (2008) - "Critical Statewide Physician Shortages in Maryland"

A study commissioned by the Maryland Hospital Association, with the support of MedChi, the Maryland State Medical Society, found that overall Maryland is 16% below the national average for the number of physicians available for clinical practice. The shortage of physicians has most affected Southern Maryland, Western Maryland, and the Eastern Shore and all three regions fall significantly below national levels in active practicing physicians. One of the reasons for these shortages is an aging workforce with 33.4 percent of physicians over age 55. Some changes that could curtail the imminent crisis are: initiate a state loan forgiveness program that draws physicians to regions in need, increase the number of residency slots, and offer incentives to encourage physicians to practice in the state's rural areas.[18]

Massachusetts (2010) – "Physician Labor Market Continues to be Under Extreme Stress"

For nine years in a row, the Massachusetts Medical Society has conducted a physician workforce study and each successive report points to a strained health care market. This most recent report has identified 10 physician specialties that meet the classification for critical or severe conditions in the labor market up from 7 in 2009. The specialties where shortages have been noted are: dermatology, emergency medicine,

family medicine, general surgery, internal medicine, orthopaedics, psychiatry, neurology, urology, and vascular surgery. Both family medicine and internal medicine are characterized as critical while the rest are deemed severe. The demand for services in these specialties has surpassed the supply in the state. As new health care initiatives go into effect, this could further strain the state's ability to meet demand for services.[19]

Michigan (2006) – "Growth in Demand Will Outpace Growth in Supply"

A study by the Center for Health Workforce Studies at the University of Albany, State University of New York concluded that between 2005 and 2020, growth in the demand for physicians in Michigan will likely outpace growth in the supply of physicians. Michigan is likely to face a physician shortage by 2020. The severity of this shortage is expected to be about 4,400 physicians, or about 12% of the number of physicians required to meet the forecasted demand for medical services in 2020.[20]

Minnesota (2008) – "Physician Supply in Minnesota is Diminishing"

According to a study by the Minnesota Hospital Association Board of Directors, Minnesota's physician workforce is waning. Nearly half (45%) of Minnesota's physicians are over the age of 50 and the 65 and older population is projected to increase by 58% by 2020. Only 5% of all Minnesota physicians practice in rural areas, while 13% of Minnesotans live there. Rural areas also suffer from having too few specialists as physician distribution is becoming a bigger problem in the southern and northern rural areas. Physician recruitment and retention strategies must be developed for and by Minnesota hospitals to ensure the state's ability to provide quality health care.[21]

Mississippi (2003) – "Extant Physician Shortage will Become More Severe"

Even before hurricane Katrina devastated the gulf coast region, Mississippi was facing a shortage of physicians. Findings presented in a 2003 white paper by the Health Policy Research Center at Mississippi State University indicate an "extant physician shortage will become more severe." Over half (56%) of the states physicians practice in four counties and 2 out of 3 counties are officially designated health professional shortage areas (HPSAs) with high levels of chronic illness and poverty. A survey of practicing physicians indicates that many are considering relocation or early retirement which will likely exacerbate the current shortages.[22]

Missouri (2009) – "Recruitment and Retention of Health Care Providers Very Difficult"

A 2009 study by the Health Management Associates, Inc. and funded by the Missouri Foundation for Health and the Healthcare Foundation of Greater Kansas City, suggests that Missouri has a shortage of healthcare professionals based on the ratio of the population to the availability of healthcare services. Missouri is experiencing the most acute shortage of physicians in rural areas shown by the fact that 40% of the population resides in rural areas but only 25% of the state's physicians practice there. The access to healthcare in rural areas is compounded by the fact that the rural population is generally older, requiring more services and includes a rapidly growing Hispanic population which raises cultural and language challenges.[23]

Montana (2009) – "We are not Prepared for the Health Workforce Shortage"

In a report put out by the Montana Office of Rural Health (MORH) a serious shortage of primary care physician services is cited in Montana. The distribution of physicians in Montana is extremely uneven with 37% of all primary care physicians practicing in only three cities and 40 of Montana's 56 counties are designated HPSAs. Furthermore, there are 9 counties without any physicians, 12 counties with no primary care physicians, and 7 counties without any hospitals. For Montanans living in rural areas, access to primary care is much more limited than that of their counterparts in Montana's urban centers. Exacerbating the shortage of healthcare services is the fact that there is no medical school in Montana

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and only 20 students a year are able to receive a publicly sponsored medical education through the WWAMI program at the University of Washington.[24]

Nebraska (2008) – "Over 1/3 of all Physicians in Nebraska are Older than 50 Years"

In a recent study by the Nebraska Center for Rural Health Research it was reported that only 9 of Nebraska's 93 counties have a physician-to-population ratio above the 2004 national average ratio of 214.09 physicians per 100,000 population. It is expected that in the next 10 to 15 years over a third of all Nebraska's physicians will retire. Furthermore, Nebraska has not developed an all-inclusive plan to predict the need for health care services or stayed in touch with innovations in training programs to meet future needs for professionals who practice effectively in health care teams. A task force has been established to look at the health workforce issues that are currently facing Nebraska.[25]

Nevada (2009) – "Nevada Currently Ranks 48th in the Number of Physicians per Capita"

A 2009 report by The Center for Education and Health Services Outreach (CEHSO) at the University of Nevada School of Medicine describes the changing face of the physician workforce in Nevada. The makeup of practicing physicians in Nevada is characterized by growth in the proportion of female physicians and by growing percentages of older physicians nearing retirement. Furthermore, only 5 out of 39 specialties have practicing physicians at a per capita level higher than other states in the region and only 2 higher than the national average leaving Nevada experiencing shortages for most medical and surgical specialties. Also troubling is the fact that Nevada only has 218 physicians per 100,000 of the population while the national average is 307. A 2006 report by LarsonAllen, a Minnesota consulting firm charged with reviewing Nevada medical education capacity and need, recommends that the state develop a health sciences center in order to dramatically increase medical school and graduate medical education training opportunities. With one of the lowest physician to population ratios and one of the highest population growth rates in the nation, the existing medical education system cannot keep up with the need.[26]

New Jersey (2009) – "Facing Significant Future Shortages"

A report by the New Jersey Council of Teaching Hospitals projects New Jersey will experience a significant shortage of physicians in both primary care and several specialties. In 2020 the state will be lacking over 2,800 physicians, approximately 1,000 in primary care and 1,800 specialists, beyond the existing GME pipeline. This data represents a 12% gap between physician supply and the demand for physician services. The council recommends expanding retention and recruitment initiatives and consistently monitoring the supply and demand for physicians in New Jersey.[27]

New Mexico (2006) – "Long History of Being a Physician Shortage State"

New Mexico's population is both growing and aging and as the population ages, the health needs, expectations and wealth of baby boomers may motivate and enable them to use more health care services. Only Los Alamos County, with a rate of 2.41 physicians per 1,000 population, came close to the national average of 2.42, and all other counties were far below. The distribution of physicians is still a major concern with more than half of New Mexico's physicians located in Bernalillo County. Furthermore, New Mexico relies on other states to provide physician supply with three quarters of physicians being trained out of state. In order for New Mexico to have sufficient supply of physicians in the future, ongoing monitoring of the status of the physician workforce is essential. [28]

New York (2007) – "Upstate New York Reported Most Difficulty Recruiting"

A report by the Center for Health Workforce Studies noted that hospitals in upstate New York were experiencing difficulties in recruiting and retaining pharmacists, physical therapists, medical laboratory technicians as well as experienced RNs and PAs. A general regional shortage of health workers as well as low salaries, were cited as the main reasons for the recruiting problems. Around 50% of hospitals in the region reported problems hiring part-time workers and 36% reported difficulty finding bilingual, Spanish-speaking workers.[29]

North Carolina (2007) – "State Likely to Face a Severe Shortage Over Next 20 Years"

A Task Force convened by the North Carolina Institute of Medicine concluded that without major changes in the health care delivery system or significant increases in the number of physicians, the state is likely to face a severe shortage of physicians. The projected shortages are not limited to physicians and will also include nurse practitioners, physician assistants and certified nurse midwives. The projected gap is mainly due to population growth, aging of the population and providers, and the increasing prevalence of chronic diseases.[30]

Oregon (2004) – "Looming Shortage of Physicians"

Oregon Health & Science University's Center for Rural Health has been collecting workforce data since the mid-70's; 2004 data suggests a "looming shortage of physicians." Population growth in Oregon exceeds growth in the number of physicians; nearly half of the state's practicing physicians are over 50 and approaching retirement age. This comes at a time when the state is already experiencing shortages in rural areas and in several specialties, including rheumatology, nephrology, gastroenterology, cardiology, allergy-immunology and pediatrics.[31]

Pennsylvania (2008) – "Pennsylvania's Physician Numbers Have Not Been Growing"

A report by the Pennsylvania Medical Society presents a number of trends that raise concerns regarding the future supply of physicians. The report points out that the physician workforce in Pennsylvania is old, with 50% of their physicians over the age of 50 and less than 8% of their physicians are under the age of 35. With increasing demand for health services outpacing supply, physicians are needed to work more hours and this negative trend could make retention and recruitment more problematic. Another problem is the residency retention rate which dropped from 60% in 1992 to only 22% in 2006. Specialty specific physicians have been on the decline since 1997 especially in the areas of family medicine, internal medicine, obstetrics and gynecology, cardiology, pathology, orthopedic surgery, general surgery, and neurosurgery.[32]

Texas (2008) – "Physician to Population Ratios Increasingly Unfavorable"

The Texas Higher Education Coordinating Board released a report in 2002 stating that, "if the number of physicians does not increase, the [physician to population] ratios will become increasingly unfavorable." An update of the 2002 report released in 2008 highlights some of the efforts that Texas is implementing to alleviate a shortage of physicians. While the number of Texas medical school applicants has increased by 40% since 2002 and 4 schools have added more than 20 new slots, problems such as an aging population and maldistribution of physicians continue to plague the state. In addition, underserved populations and the under-representation of Hispanics and African-Americans in the workforce are critical issues for the state.[33] The Texas Tech University Health Sciences Center's El Paso Paul L. Foster School of Medicine is the first new Texas medical school in 30 years becoming a fully operational four-year medical school in 2009 with a class of 40 students.[34]

Utah (2006) – "Shortages Exist in many Specialties"

In 2003, the Utah Medical Education Council sent a survey to all practicing physicians licensed in the state to better understand the existing workforce and to forecast future supply and demand. There are current shortages in pediatric neurology, child psychiatry, adult psychiatry, obstetrics & gynecology, general surgery, dermatology, urology, and cardiology. The state will need to recruit up to 270 physicians a year in order to keep up with growth in demand due to the growth and aging of the population and to replace loss of FTEs due to retirements. Given the nationwide shortages, it will be a challenge to even maintain current recruitment levels.[35]

Vermont (2010) - "Overall Supply of Primary Care Practitioners is Below Adequate Levels"

The Vermont Area Health Education Centers (AHEC) Network released a report detailing the primary care workforce in the state and found that the number of primary care physicians falls short of the number needed to care for all Vermont residents and is prevalent in all counties. In addition the report states that 34% of all primary care physicians are either not accepting or limiting their acceptance of new patients increasing from 31% in 2008. Shortages in primary care in Vermont are due to the aging of both the population and the physician workforce, the accompanying increases in chronic illnesses brought on by an elderly population, and the smaller supply of new primary care physicians affecting the nation as a whole. To remedy the shortfall of primary care physicians in the state there have been focused efforts, by AHEC and other collaborators, on pipeline development, recruitment, retention, and continuing education of the primary care workforce.[36]

Virginia (2007) - "Virginia Must Begin Acting Now to Increase Physician Workforce"

In the Report of the Governor's Health Reform Commission it is estimated that by 2020 there will be a shortage of approximately 1,500 physicians in Virginia. Physician retention is the primary issue in the supply of Virginia's doctors with only 28% of active physicians in the state who completed a residency or fellowship there. It is also estimated that by 2020 the state will need of 22,600 full-time RNs. By 2030 25% of the state's population will be over the age of 60 meaning more people will be making more frequent doctor's visits. If the state could work to increase its current retention rate (36%) as well as increasing medical school class size, there is a greater chance of stemming this shortage. The Report also recommends increasing funds for scholarship and loan repayment programs.[37]

Wisconsin (2008) – "Who Will Care for Our Patients?"

A 2008 report updating an earlier 2004 report from the Task Force on Wisconsin's Future Physician Workforce, entitled "Who Will Care for Our Patients? Wisconsin Takes Action to Fight a Growing Physician Shortage" concluded that Wisconsin has current unmet needs for physician services that are likely to worsen in the foreseeable future. Shortages are most severe in rural and inner-city areas of the state. Areas of Milwaukee and other Health Professional Shortage Areas are in dire need of primary care physicians specifically.

Wyoming (2008) – "Major Primary Care Provider Shortages"

The University of Washington's Center for Health Workforce Studies completed a study of the primary care workforce in Wyoming a rural frontier state, and found a definite shortage of physicians in Wyoming. The report notes that more than two-thirds of Wyoming's counties (15 out of 23) have fewer primary care providers than the national average and 20 out of 23 Wyoming counties (87%) have fewer than the national average of primary care physicians per 100,000 population. In three rural counties, over a third of all physicians indicated they would retire in the next 5 years (by 2012) and about 15% of

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primary care physicians statewide plan to retire by the same date. Wyoming has trouble importing physicians since no medical school or physician assistant education programs exist in Wyoming.[38]

SPECIALTY SPECIFIC STUDIES

Recent workforce studies indicate that we face current and future shortages in a wide array of specialties. In addition to potential shortages in primary care specialties, as the population ages, the demand for specialists that provide care for patients over 65 will increase significantly. As indicated by a number of the studies below, the aging of the population is expected to contribute to shortages in many of these specialties.

Allergy and Immunology (2006) – "Shortage within Next Ten Years"

A June 2000 report prepared for the American Academy of Allergy, Asthma, and Immunology by SUNY Albany's Center for Health Workforce Studies concludes, "there will be a shortage of allergist/immunologists within the next ten years." Demand is rising and the supply of new physicians will not be able to keep pace with the current retirement rate of practicing allergists and immunologists and unable to meet the projected increase in demand.[39] A follow-up report in June of 2006 also by the Center for Health Workforce Studies notes "The prevalence of asthma and allergy-related disorders in American continues to increase. Allergies affect as many as 40 to 50 million people in the United States, more than 20 percent of the nation's population." Despite this large demand for services, a relatively small number of physicians specialize in Allergy and Immunology. In fact, between 1990 and 1998 the number of physicians training in Allergy and Immunology fellowships declined 34%. The rising demand for services coupled with the low rates of new physicians entering into the specialty are some reasons cited for the projected shortfall.[40]

Anesthesia (2003) – "Current Shortfall of Anesthesiologists"

A 2003 assessment of the supply of and demand for anesthesiologists found a current shortage. There was not enough data to determine with confidence how demand for anesthesiologists would change in the coming years. If demand increases above 1.5%, the authors project a continued shortage through 2015.[41]

Cardiology (2009) – "Currently a Substantial Shortage of Cardiologists"

In 2009, the Lewin Group conducted an assessment of the supply and demand for cardiologists for the American College of Cardiology (ACC) and the American College of Cardiology Foundation. The study concluded that there is currently a substantial shortage of cardiologists and that this shortage will increase over the next 20 years. The key drivers of the shortage are a higher demand for cardiology services, as the general population ages, coupled with the fact that 43% of general cardiologists are currently over the age of 55 and will likely retire in the next 20 years. The shortage of general cardiologists is projected to increase from about 1,700 in 2008 to about 16,000 in 2025. An earlier, 2004, study by The American College of Cardiology (ACC) Task Force on Workforce concluded that the U.S. is facing a "serious shortage of cardiologists." Additionally, report from their 35th Bethesda Conference, endorsed by the American Heart Association and a host of other cardiology-related societies, predicts that, by 2020, there will be a 20% decrease in the age-adjusted supply of cardiologists at the same time we will see a substantial increase in the incidence and prevalence of cardiovascular disease due to the aging of population and the epidemic of obesity.[42 43 44]

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Child Psychiatry (2006) – "Evident Shortage Will Continue Well into the Future"

A 2003 Academic Psychiatry article finds that, "despite the decades-long projection of an increasing utilization of child and adolescent psychiatry services and an undersupply of child psychiatrists, the actual growth and supply of child and adolescent psychiatrists has been very slow." A 1990 report by the Department of Health and Human Services concluded the nation should have over 30,000 child psychiatrists but there are less than 7,000 currently practicing in the nation.[45]

Critical Care Workforce (2006) – "Growing Supply of Intensivists will be Insufficient"

In June 2003, Congress asked HRSA to examine the adequacy of the critical care workforce in response to concerns that the number of pulmonary and critical care physicians would not be able to meet the needs of the aging baby boomer population. HRSA worked with the College of Chest Physicians to update physician workforce models to include critical care physicians and found that "demand for intensivists will continue to exceed available supply through the year 2020 if current supply and demand trends continue." [46]

Dermatology (2008) – "Stable Undersupply of Dermatologic Services"

In an article published in the Journal of the American Academy of Dermatology, an update from a 2002 article, "a stable undersupply of dermatologic services has been reported in the United States, with a mal-distribution of physicians exacerbating the problem." This shortage comes at a time when the demand for dermatologists is rising due to the aging population and the increasing occurrence of various skin diseases. In the last five years, dermatologists increased the use of PAs or NPs by 43%. The 2002 study noted that nearly half of practicing dermatologists believe their community could use more dermatologists and one third are recruiting new associates and new graduates are readily able to find jobs.[47]

Emergency Medicine (2009) – "Emergency Care System Remains in Serious Condition"

In 2009, the American College of Emergency Physicians released the National Report Card on the State of Emergency Medicine and "access to emergency care" received a "D". The reason for this dismal grade is the fact that the nation has too few emergency departments to meet the needs of a growing and aging population. Over the past 10 years, the number of people needing emergency care annually has increased 32%, from 90.3 million to 119.2 million. At the same time, the number of hospital emergency departments in the country has dropped nearly 7%, from 4,109 to 3,833. Another paper on shortages in the Emergency Medicine workforce was published in 2009 in *Annals of Emergency Medicine.* In 2006, the IOM released a series of three reports on the future of emergency medicine concluding that emergency departments and ambulatory services are overburdened, under-funded, and highly fragmented. Patients face long waits in overcrowded emergency rooms and often needed on-call specialists are not available. A significant contributing factor is that more and more patients are turning to emergency departments for care because of lack of insurance, for after-hours care, or due to limited options in rural communities. [48] [49]

Endocrinology (2003) – "Demand Will Exceed Supply from Now until 2020"

According to a study published jointly in the May 2003 issues of the journals Endocrine Practice, Diabetes Care, and the Journal of Clinical Endocrinology & Metabolism, the supply of newly trained endocrinologists will not be sufficient to offset retirements and future increases in demand. As it stands, current demand exceeds supply by 15% and the aging of the population compounded with physician retirements will exacerbate the situation. The authors present multiple models for estimating the future

demand for endocrinologists and even the conservative estimates predicate a widening shortage by 2020.[50]

Family Physicians (2006)–"Declining Medical Student Selection of Family Medicine"

A report by the American Academy of Family Physicians states that in order for the country to have enough physicians to meet the demands of the population in 2020, a typical accredited family medicine residency program would need to increase from an average of 21.7 residents to 24 residents. The report suggests recruiting diverse candidates to become family physicians who will most likely serve rural, underserved, and elderly patients.[51]

Gastroenterology (2009) – "A Shortfall of Gastroenterologists Projected by 2020"

In a 2009 report, the Lewin Group found that gastroenterologists are crucial for detecting colorectal cancer (CRC) as they provide the majority of colonoscopies. A shortfall of approximately 1,050 gastroenterologists is expected by 2020 as demand for colonoscopies is expect to rise by 10 percentage points. Both the aging and growth of the population is causing demand to exceed supply and the number of gastroenterologists entering the field are not going to be able to meet the needs of the growing and aging population.[52]

General Surgery (2007) – "General Surgeon to Population Ratios Declined Steadily"

A longitudinal study published in the Archives of Surgery on general surgeons from 1981 to 2005 shows a constant decline. There are 723 fewer general surgeons practicing today than were in 1981. The general surgeon to population ratio decreased steadily across the study period, from 7.68 per 100,000 in 1981 to 5.69 per 100,000 in 2005. The overall number of general surgeons has remained static since 1994, despite an increase in the population of 1% per annum during this period. This coupled with the rise in surgical specialization and the decreased interest among medical student's in general surgical careers has generated concern over a shortage.[53]

Geriatric Medicine (2009) – "The Healthcare Workforce Receives little Geriatric Training"

The Association of Directors of Geriatric Academic Programs (ADGAP) recently completed a three year study of the newly implemented programs sponsored by foundations, state and federal budgets to address the shortage of Geriatric physicians that was cited in an Institute of Medicine study. The main obstacle cited for training new Geriatricians is that there are only 14 departments of geriatric medicine in the country, many of which have small operating budgets. In the 2007 AAMC graduating medical student survey, only 23% of students strongly agreed that they were exposed to expert geriatric care. Moreover, as the nation's 78 million baby boomers begin to retire, a report issued by the Institute of Medicine concludes that the healthcare workforce is not prepared to offer the best care to older patients. Only a small percentage of physicians specialize in geriatric medicine because of the high cost associated with extra years of training and the relatively low pay. The study recommends that incentives be provided to increase the number of geriatric specialists such as higher pay, loan repayment, and scholarships.[54] [55]

Medical Genetics (2004) – "Situation is Critical"

An October 2004 Report of the Banbury Summit Meeting on Training of Physicians in Medical Genetics states that "the medical genetics workforce situation is critical." As the scope of practice for geneticists increases beyond rare pediatric disorders and becomes increasingly relevant to common health concerns (including some forms of cancer and a number of neurological and cardiovascular disorders), declining numbers of physicians are going into the field. 58% of clinical genetics GME slots

are unfilled. 17 states currently have shortages and the 5 to 15 year forecast indicates further shortages.[56]

Neurosurgery (2005) – "Severe Decline in Number of Active Neurosurgeons"

According to a study published in the February 2005 issue of the Journal of Neurosurgery the nation is encountering a "severe decline in the number of active neurosurgeons and a static supply of residents." The number of practicing neurosurgeons has declined while at the same time there has been a significant increase in the demand for neurosurgeons. Evidence cited includes a doubling in the average number of journal-advertised academic and private neurosurgery positions per year between 1994 to1998 and 1999 to 2003.[57]

Neurology (2010) – "Shortage of Neurologists Likely to Continue"

In a study published by *Neurologic Clinics*, the uneven distribution of neurologists, resulting in shortages in rural areas is reported. The maldistribution ranges from 11.02 per 100,000 population in Washington, DC, to 1.78 per 100,000 population in Wyoming. This shortage of neurologists similar to that of other specialists in underserved and rural areas is expected to continue given the high overhead and salary costs necessitating a steady supply of patients. Neurologists have historically been concentrated in urban areas but with an increase in the elderly population, acute stroke care evaluation and management will be challenging for rural populations. Additionally, shortages of neurologists are expected to continue due to an essentially level or declining number of new neurologists and the increased subspecialization of those new neurologists.

Oncology (2007) – "Oncology Moving to a State of Acute Shortages in 2020"

A 2007 report in the Journal of Oncology Practice concludes that the nation will face a shortage of oncologists if current cancer rates and practice patterns continue. Demand is projected to increase by 48% by 2020 due to the growth in the aged population and to the increasing number of cancer survivors. Supply is only projected to increase by 14% by 2020 due to physician retirements and limited expected growth in the number of oncology fellowship training slots. The authors note there are opportunities to minimize the gap in supply and demand but that no single remedy alone can fully address the likely shortage.[58]

Pediatric Subspecialties (2007) - "Pediatric Subspecialty Care is in a Crisis"

The Expert Work Group on Pediatric Subspecialties has determined that the main causes for the crisis in pediatric subspecialties are an insufficient number of specialists, an increasing demand for these services, and not enough funding for medical education. The lack of available care harms children and families and produces pricey inefficiencies in the healthcare system as a whole. The report recommends making access to these subspecialties a priority in medical home reform efforts and increasing collaboration among specialists in pediatrics care at the local and regional levels.[59]

Primary Care (2006) – "Primary Care on the Verge of Collapse"

In 2006, the American College of Physicians released a report entitled "The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation's Health Care". At a time of growing demand for primary care due to growth in the number of people with chronic diseases and long term care needs of an aging population, there has been a decline in the number of medical students entering primary care. The authors cite a number of policy recommendations for averting a crisis, including implementing the advanced medical home (a care coordination model), reforming reimbursement policies, and creating financial incentives for improving quality and efficiency.[60]

The numbers of generalist residency graduates have declined each year since 1998, causing concern about future shortages says a study published in *Health Affairs*. Furthermore, between 2005 and 2025 the population above age 65 will increase 73 percent, the same group who seeks care from generalists at twice the rate of those under the age of 65. Using 2005 levels as a benchmark, a 20-27 percent shortfall, about 35,000 to 44, 000 generalists, is anticipated by 2025. The major decline is attributed to more and more graduates in internal medicine sub-specializing. To increase the number of generalists, the authors recommend that reimbursement reform realigning incentives to make the "medical home" financially viable should be at the top of the list. [61]

Psychiatry (2003) – "Unclear Rate of Growth will Keep Up with Demand"

In the Winter 2003 issue of Academic Psychiatry, an analysis of the current psychiatric workforce trends makes it doubtful "the rate of growth will be able to keep up with the rate of growth of demand." The average age of practicing psychiatrists is 55.7 and the percentage under 40 dropped from 24% in 1989 to 8% in 2002. Additionally, analysis of the Professional Activities Survey data reveals reductions in the average number of hours worked per week and in the percent of time psychiatrists spend in direct patient care.[62]

Public Health (2008) – "Public Health Workforce Shortages Imperil Nation's Health"

A research brief by the Center for Studying Health System Change reports that local health departments are facing a workforce crisis in that they are unable to recruit, train, and retain Public Health workers to meet communities' needs. Some factors leading to this shortage are inadequate funding, uncompetitive salaries and benefits, large numbers of retiring workers, not enough currently trained workers, and a general lack of enthusiasm for service in public health. Public health workers provide essential services and without enough of these workers the public's health would suffer drastically.[63]

Rheumatology (2007) – "Shortage Exists Now and is Likely to Worsen"

In a 2007 Arthritis and Rheumatism article, the authors predict substantial excess in demand relative to the supply of rheumatologists between 2005 and 2025. The nation is facing an increasing prevalence of musculoskeletal diseases due to the growth and aging of the population at a time when the supply of rheumatologists is not projected to increase. The authors note it appears there is a current shortage as a survey of rheumatologists reveals an average wait for a new appointment of 38 days.[64]

Thoracic Surgery (2009) – "Projections of a Shortfall"

A new study in *Circulation* explores the fact that cardiovascular disease, currently responsible for a third of American deaths, will remain the leading cause of mortality and morbidity for the elderly, whose numbers will double between now and 2030. Not only will the population require more thoracic surgery services but the number of active cardiothoracic surgeons has fallen for the first time in 20 years and by 2025, it is probable that there will be a shortage of at least 1,500 surgeons. The supply alone of cardiothoracic surgeons will fail to meet the demands of an expanding and aging US population and with the expected increase in demand; the shortfall will be even greater. [65]

NATIONAL REPORTS

"Physicians and Their Practices Under Health Care Reform" - The Physicians Foundation, Inc. (2009)

In the wake of health care reform, the Physicians Foundation saw a need for a "critical analysis of how various proposed changes might affect the demand for physicians and the ability of their practices to

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provide optimum patient care." The Team of experts rejected the notions that higher use of physician services in certain areas is considered "overuse" and that savings could be found by reducing the volume of care in these areas. Through an assessment of the future demand for physician services, the Team endorsed the recent reports citing a shortage of physicians in different specialties and geographic regions. In light of the shortage of physicians, the Team recommends training more physicians, removing the cap on GME positions, that was established a decade ago, and creating new medical schools. Training healthcare workers at all levels, from physicians to aides, is essential in creating a functioning healthcare system and must begin immediately given the duration of training required. Overall, this report, "projects the size and characteristics of the physician workforce that will be required in the future, while recognizing that, because of the long lead times in training physicians, health care will have to be structured around persistent physician shortages for a decade or more." [66]

"The Complexities of Physician Supply and Demand: Projections Through 2025" – Association of American Medical Colleges (2008)

Using the most recently available data, a new report by the AAMC Center for Workforce Studies projects future supply and demand for physicians and concludes that a national shortage is likely Driven by such factors as U.S. population growth, aging population and doctors, and increased physician visits, the demand for doctors will outstrip the supply through at least 2025. If physician supply and use patterns stay the same, the United States will experience a shortage of 124,000 full-time physicians by 2025. US medical schools are increasing their enrollment as recommended by the AAMC. The report concludes that while this increase is necessary, it will not be sufficient to meet future patient needs and demand. Actions beyond increasing the supply of physicians will be needed. Complex changes such as improving efficiency, reconfiguring health care delivery, and making better use of both physicians and other health care professionals will also be necessary.[67]

"Out of Order out of Time" - Association of Academic Health Centers (2008)

In a report by the Association of Academic Health Centers (AAHC) the dysfunction of public and private health workforce planning is highlighted and a call is given to implement a comprehensive national policy with effective solutions. The study claims that too many entities are controlling health workforce policy making which leads to a limited focus instead of a broad strategic vision and short term decisions driven by responses to crisis rather than long term planning. A broader integrated approach is recommended where the Federal Government is in charge of workforce planning and it becomes a priority domestic policy issue.[68]

"Growth and Aging of the U.S. Population will Cause a Surge in Demand" – The Federal Department of Health and Human Services (DHHS) (2006)

The Health Resources and Services Administration (HRSA) in the U.S. Department of Health and Human Services (DHHS) released a report in 2006, projecting a shortfall of approximately 55,000 physicians in 2020. If current trends continue, the full time equivalent (FTE) physician supply is projected to grow to 866,400 by 2020, while demand for physicians will increase to 921,500 due to the growth and aging of the U.S. population. The report projects shortages will be in greatest in non-primary care specialties.[69]

"U.S. Likely to Face a Shortage in 2020" – U.S. Council on Graduate Medical Education (COGME) Report (2005)

In January 2005, the Council on Graduate Medical Education (COGME) released its 16th Report, "Physician Workforce Policy Guidelines for the United States, 2000-2020" recommending an increase

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of 3,000 medical school graduates by 2015 in order to meet rising demand and need. Only under the most optimistic of various supply and demand scenarios outlined in the report would the nation have an adequate supply to meet demand in the year 2020. When the mid-points of the projected supply and demand scenarios outlined in the report are used, the net result is a projected shortage of about 85,000 physicians in 2020 – which is equivalent to approximately ten percent of today's physician workforce.70

"America is Running out of Physicians" – Merritt, Hawkins & Associates (2004)

In 2004, Merritt, Hawkins & Associates, a health care staffing and consulting firm, published, "Will the Last Physician in America Please Turn off the Lights? A Look at America's Looming Doctor Shortage." The authors predict there will be a shortage of 90,000 to 200,000 physicians and that average wait times for medical specialties are likely to increase dramatically beyond the current range of two to five weeks. Various factors, including the demise of managed care, the aging of the population, changing practice patterns, increasing regulation and paperwork are some of the reasons cited for the impending shortage.[71]

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SENATE BILL No. 1116

May 3, 2012, Introduced by Senators MEEKHOF, MOOLENAAR and SMITH and referred to the Committee on Insurance.

A bill to amend 1961 PA 236, entitled

"Revised judicature act of 1961,"

by amending section 2912a (MCL 600.2912a), as amended by 1993 PA 78.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 2912a. (1) Subject to ~~subsection~~ SUBSECTIONS (2) AND (3), in an action alleging malpractice, the plaintiff has the burden of proving that in light of the state of the art existing at the time of the alleged malpractice:

(a) The defendant, if a general practitioner, failed to provide the plaintiff the recognized standard of acceptable professional practice or care in the community in which the defendant practices or in a similar community, and that as a proximate result of the defendant failing to provide that standard, the plaintiff suffered an injury.

SENATE BILL No. 1116

(b) The defendant, if a specialist, failed to provide the recognized standard of practice or care within that specialty as reasonably applied in light of the facilities available in the community or other facilities reasonably available under the circumstances, and as a proximate result of the defendant failing to provide that standard, the plaintiff suffered an injury.

(2) In an action alleging medical malpractice, the plaintiff has the burden of proving that he or she suffered an injury that more probably than not was proximately caused by the negligence of the defendant or defendants. In an action alleging medical malpractice, the plaintiff cannot recover for loss of an opportunity to survive or an opportunity to achieve a better result. ~~unless the opportunity was greater than 50%.~~

(3) A PERSON DESCRIBED IN SECTION 5838A(1) IS NOT LIABLE IN AN ACTION ALLEGING MEDICAL MALPRACTICE IF THE PERSON'S CONDUCT AT ISSUE CONSTITUTED THE EXERCISE OF PROFESSIONAL JUDGMENT. FOR PURPOSES OF THIS SUBSECTION, A PERSON EXERCISES PROFESSIONAL JUDGMENT IF THE PERSON ACTS WITH A REASONABLE AND GOOD-FAITH BELIEF THAT THE PERSON'S CONDUCT IS BOTH WELL FOUNDED IN MEDICINE AND IN THE BEST INTERESTS OF THE PATIENT. IN AN ACTION DESCRIBED IN THIS SUBSECTION, ALL OF THE FOLLOWING APPLY:

(A) THE ISSUE OF WHETHER AN ACT OR OMISSION WAS AN EXERCISE OF PROFESSIONAL JUDGMENT IS A QUESTION OF LAW FOR THE COURT.

(B) IF THE COURT DETERMINES UNDER SUBDIVISION (A) THAT THE PERSON DESCRIBED IN SECTION 5838A(1) DID NOT MEET THE BURDEN OF PROVING THAT THE ACT OR OMISSION WAS AN EXERCISE OF PROFESSIONAL JUDGMENT, THE QUESTION OF WHETHER THE PERSON FAILED TO PROVIDE THE

RECOGNIZED STANDARD OF ACCEPTABLE PROFESSIONAL PRACTICE OR CARE IS A QUESTION FOR THE TRIER OF FACT TO DECIDE. THE RULING OF THE COURT UNDER SUBDIVISION (A) IS INADMISSIBLE AS EVIDENCE AT TRIAL, AND THE COURT SHALL NOT PERMIT THE PARTIES' COUNSEL TO ARGUE ANY PROVISION OF THIS SUBSECTION TO A JURY.

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Positive
As of: May 21, 2012

ARTHUR LOUIS SIMKO, MARGARET A. SIMKO, and TARA MARIE SIMKO, Plaintiffs-Appellants, v MARVIN BLAKE, Attorney at Law, Defendant-Appellee.

No. 97579

SUPREME COURT OF MICHIGAN

448 Mich. 648; 532 N.W.2d 842; 1995 Mich. LEXIS 842

October 5, 1994, Argued
May 23, 1995, Decided
May 23, 1995, FILED

PRIOR HISTORY: [***1] *201 Mich App 191; 506 NW2d 258 (1993).*

DISPOSITION: Affirmed.

COUNSEL: E. Robert Blaske, Battle Creek, MI. and Thomas H. Blaske, Ann Arbor, MI, for the plaintiffs.

Plunkett & Cooney, P.C. (by Christine D. Oldani, Mary Massaron Ross, and Patrick M. Barrett), Detroit, MI, for the defendant.

JUDGES: BEFORE THE ENTIRE BENCH (except Weaver, J.). Chief Justice James H. Brickley, Justices Charles L. Levin, Michael F. Cavanaugh, Patricia J. Boyle, Dorothy Comstock Riley, Conrad L. Mallett, Jr., Elizabeth A. Weaver. LEVIN, J. (dissenting).

OPINION BY: Conrad L. Mallett, Jr.

OPINION

[*650]

[**844] **Opinion**

MALLETT, J.

This case presents the question whether an attorney's duty to his client extends beyond what is legally adequate to win a client's case. We hold that attorneys must only act as would an attorney of ordinary learning, judgment, or skill under the same or similar circumstances.

Defendant Blake raised a complete defense, did what was legally sufficient to fully vindicate his client's interest, and acted as would an attorney of ordinary learning, judgment, or skill under the same or similar circumstances. His alleged acts and omissions were trial tactics based on good faith and reasonable professional [***2] judgment. Further, no amount of factual development could reveal a case of malpractice. Thus, we affirm the decision of the Court of Appeals in favor of the defendant.

I

Plaintiffs Arthur Louis Simko, Margaret Simko, and Tara Marie Simko filed suit against defendant Marvin Blake, an attorney, alleging that the defendant committed professional malpractice in failing to adequately represent Arthur Simko in a prosecution of possessing over 650 grams of cocaine, [*651] *MCL 333.7401(2) (a) (i)*; MSA 14.15(7401) (2) (a) (i), and possession of a firearm in the commission or attempt to commit a felony, *MCL 750.227b*; MSA 28.424(2). Although the defendant was convicted and the conviction eventually was re-

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versed by the Court of Appeals, Mr. Simko spent more than two years in prison.

In the underlying criminal case, on the night of March 6, 1987, a state police officer observed a speeding car traveling with its lights flashing in an apparent effort to attract the officer's attention. The car exited the highway and stopped to wait for the police car. The driver of the vehicle alighted from his car and told the police that the passenger, Arthur Simko, needed medical attention.

Plaintiff appeared flushed, [***3] was perspiring, and his breathing was labored. The officer summoned an ambulance. While waiting for the ambulance to arrive, the officer discovered what appeared to be drug paraphernalia on the floor of the car. A further search of the car revealed a cup containing cocaine residue, a bullet in plaintiff's pocket, a pistol in the glove compartment, a pistol in the trunk, several rounds of ammunition, and 988 grams of a substance containing cocaine.

Arthur Simko was represented by Marvin Blake. At the close of the prosecution's case, and again at the close of defendant's case, Mr. Blake moved for a directed verdict on the ground that the evidence was insufficient to convict plaintiff. The trial judge denied both motions. Mr. Simko was ultimately found guilty by the jury and sentenced to mandatory sentences of life without parole plus two years.

Arthur Simko then retained another attorney and appealed his conviction. The Court of Appeals [*652] reversed; however, by that time, he had already served two years of his prison sentence. [1]

1 See *People* v *Simko,* unpublished opinion per curiam, issued November 29, 1989 (Docket No. 105873).

[***4] At the time plaintiff filed his appeal, he also filed a legal malpractice action against defendant. Arthur Simko alleged that the defendant failed to properly investigate his case and failed to properly prepare to defend him. [2] Specifically, Mr. Simko [*653] alleged [**845] that Mr. Blake did not produce any witnesses in his defense besides Mr. Simko himself, failed to produce plaintiff's personal physician who had been treating him for a pinched nerve and who prescribed medication that would have offered an explanation of his medical condition at the time of arrest, and failed to provide Mr. Simko with the name and location of the hotel where Mr. Simko had spent the day before he was arrested that may have protected him from impeachment.

2 Plaintiff alleged the following:

a. Failed to adequately and properly investigate Mr. Simko's case;

b. After some three months involvement with the case had, at that point, failed, refused and/or neglected to discover the identity and whereabouts of essential witnesses necessary to substantiate Mr. Simko's defense;

c. At trial, another four months after the pre-trial conference and seven months since he had first become involved, still had not done anything to assist Mr. Simko in defense of the charges against him;

d. After claiming to have two or three defense witnesses to produce at trial, he only produced Arthur Louis Simko himself as a witness;

e. Failed to call the personal physician of Mr. Simko, Dr. Michael Karbal, of Troy, who had been treating Mr. Simko for a pinched nerve as a result of a car accident and who had prescribed for him Valium 10 three times per day and Tylenol 4 three times per day which he was taking at the time of his arrest and which would fully explain his medical condition at that time;

f. Failed to call Margaret A. Simko who had several times seen he husband in a physical condition similar to the one he was in at the time of his arrest as a result of taking his prescribed medications;

g. Failed to call Margaret A. Simko who could confirm Mr. Simko's story regarding being asked by the insurance agent to go south with him;

h. Failed to call Margaret A. Simko who could confirm that none of the luggage in the trunk was owned by any member of the Simko family, and that in fact Mr. Simko had just rolled up his clothes in a ball and taken them;

> i. Failed to ascertain the pertinent information from a plastic bag which was in police possession and which contained on it the name and address of the hotel in Florida in the lobby of which Mr. Simko had spent the entire day, so as to instead allow Mr. Simko to be impeached during his trial testimony by the fact that he could not then remember the name of the hotel or the town that it was in;
>
> j. Failed to provide effective assistance of counsel; and
>
> k. Failed to provide reasonably prudent and proper legal services as required by Michigan law.

[***5] The malpractice action was dismissed by the trial court when it granted defendant's motion for summary disposition. The trial court stated:

> The proximate cause of his conviction was the trial court's error in denying the motion for directed verdict in favor of the defendant in the underlying case.
>
> The Court of Appeals, in holding that a directed verdict should have been granted indirectly not only stated that the trial court here erred but that the jury erred as well.
>
> By holding that the standard was satisfied for the granting of a motion for directed verdict, in effect, the Court of Appeals held that a reasonable well-instructed jury could not convict based upon the evidence presented during the course of the trial.
>
> The jury in the underlying case by virtue of the Court of Appeals decision acted unreasonably in light of evidence presented for the jury to consider.
>
> As a result, the defendant Blake cannot possibly be held responsible for the acts of an unreasonable jury.

The Court of Appeals affirmed, [3] stating that

> by challenging the sufficiency of the evidence against Simko, Blake raised a complete and ultimately successful defense to both charges. . . . [***6] Blake was not Simko's insurer against all possible misfortune . . . . His duty was to raise an adequate defense to the criminal charges, not to protect Simko from judge and jury. [*201 Mich App 191, 195; 506 NW2d 258 (1993).*]

3 In a dissenting opinion, Judge McDonald stated that the trial court erred when it granted defendant Blake's motion for summary disposition. Judge McDonald thought that it was improper for the trial court to find that plaintiff's injuries were caused by the criminal trial judge's error in not granting plaintiff's motion for summary disposition. Judge McDonald pointed out that there could be more than one proximate cause of the same injury. However, he agreed with the majority that an attorney does not have the duty to do more than what is legally adequate to vindicate a client's interests. *201 Mich App 191, 195; 506 NW2d 258 (1993).*

We affirm the decision of the Court of Appeals and hold that Marvin Blake fulfilled his duty to Arthur Simko.

II

We hold that defendant's motion [***7] for summary disposition was properly granted by the trial court because the plaintiffs failed to state a claim upon which relief can be granted. [**846] Plaintiffs' complaint and pleadings failed to state a breach of duty.

Pursuant to *MCR 2.116(C)(8)*, a motion for summary disposition is granted if the claim is so clearly unenforceable as a matter of law that no factual development could possibly justify recovery. A motion of summary disposition is tested on the pleadings alone, and all factual allegations contained in the complaint must be accepted as true. *Beaudin v Michigan Bell Telephone Co, 157 Mich App 185, 187; 403 NW2d 76 (1986); Marcelletti v Bathani, 198 Mich App 655; 500 NW2d 124 (1993).* [*655]

III

In order to state an action for legal malpractice, the plaintiff has the burden of adequately alleging the following elements:

[*654]

> (1) the existence of an attorney-client relationship;
>
> (2) negligence in the legal representation of the plaintiff;
>
> (3) that the negligence was a proximate cause of an injury; and
>
> (4) the fact and extent of the injury alleged. [*Coleman v Gurwin, 443 Mich 59, 63; 503 NW2d 435 (1993).*]

See *Espinoza v Thomas,* [***8] *189 Mich App 110, 115; 472 NW2d 16 (1991)*; *McCluskey v Womack, 188 Mich App 465, 473; 470 NW2d 443 (1991)*; *Pantely v Garris, Garris & Garris, PC, 180 Mich App 768, 778-779; 447 NW2d 864 (1989).* See also *Charles Reinhart Co v Winiemko, 444 Mich 579, 586; 513 NW2d 773 (1994).*

The first element the plaintiff must prove is "duty." "Duty" is any obligation the defendant has to the plaintiff to avoid negligent conduct. *Moning v Alfono, 400 Mich 425, 432; 254 NW2d 759 (1977).* In negligence actions, the existence of duty is a question of law for the court. *Antcliff v State Employees Credit Union, 414 Mich 624, 640; 327 NW2d 814 (1982).* See also *Moning, supra.*

In legal malpractice actions, a duty exists, as a matter of law, if there is an attorney-client relationship. "*Whenever an attorney or solicitor is retained in a cause,* it becomes his implied duty to use and exercise reasonable skill, care, discretion and judgment in the conduct and management thereof." *Eggleston v Boardman, 37 Mich 14, 16 (1877)* (emphasis added); *Babbitt v Bumpus, 73 Mich 331;* [*656] *41 NW 417 (1889).* See also *MRPC 1.0 to 1.3.* In the instant case, the parties [***9] admitted that an attorney-client relationship existed between Mr. Simko and Mr. Blake. Thus, the issue is not whether a duty existed, but rather the extent of that duty once invoked.

It is well established that an attorney is obligated to use reasonable skill, care, discretion and judgment in representing a client." *Lipton v Boesky, 110 Mich App 589, 594; 313 NW2d 163 (1981),* citing *Eggleston, supra at 16*; *Joos v Auto-Owners Ins Co, 94 Mich App 419, 422; 288 NW2d 443 (1979).* Further, according to SJI2d 30.01, all attorneys have a duty to behave as would an attorney "of ordinary learning, judgment or skill . . . under the same or similar circumstances . . . ."

An attorney has the duty to fashion such a strategy so that it is consistent with prevailing Michigan law. However, an attorney does not have a duty to insure or guarantee the most favorable outcome possible. An attorney is never bound to exercise extraordinary diligence, or act beyond the knowledge, skill, and ability ordinarily possessed by members of the legal profession. See *7 Am Jur 2d, Attorneys at Law, § 199,* p 249, n 92, citing *Babbitt, supra; Goodman & Mitchell v Walker, 30 Ala 482 (1857)*; [***10] *Glenn v Haynes, 192 Va 574; 66 S.E.2d 509; 26 ALR2d 1334 (1951)*; *Ward v Arnold, 52 Wash 2d 581; 328 P2d 164 (1958).*

In *Babbitt, supra at 337,* this Court held that

> a lawyer is not an insurer of the result in a case in which he is employed, unless he makes a special contract to that effect, and for that purpose. Neither is there any implied contract, when he is employed in a case, or any matter of legal business, that he will bring to bear learning, skill, or [*657] ability beyond that of the average of his profession.

[**847] See also *Bessman v Weiss, 11 Mich App 528; 161 NW2d 599 (1968).*

Furthermore, in *Joos, supra at 422,* the Court of Appeals held that an attorney only must act with the skill, learning, and ability of the "average practitioner of law." See also *Basic Food Industries, Inc v Grant, 107 Mich App 685, 690; 310 NW2d 26 (1981),* and *Lipton, supra.*

To require attorneys, or other professionals, to act over and beyond average skill, learning, and ability, would be an unreasonable burden on the profession and the legal system. [4] As the Court of Appeals stated:

> There is no motion that can be filed, no amount of research in [***11] preparation, no level of skill, nor degree of perfection that could anticipate every error or completely shield a client from the occasional aberrant ruling of a fallible judge or an intransigent jury. To impose a duty on attorneys to do more than that which is legally adequate to fully vindicate a client's rights would require our legal system, already overburdened, to digest unnecessarily inordinate quantities of additional motions and evidence that, in most cases, will prove to be superfluous. And, *because no amount of work can guarantee a favorable result, attorneys would never know when the work they do is sufficiently more than adequate to be enough to protect not only their clients from error, but*

themselves from liability. [*201 Mich App 194* (emphasis added).]

4 This of course does not exclude an elevated standard of care when an attorney and client enter into a contract or agreement whereby the attorney agrees to be held to a higher standard. *73 Mich 337.*

In *Denzer v Rouse, 48 Wis* [***12] *2d 528, 534; 180 NW2d 521 (1970)*, the court noted that an attorney [*658] cannot possibly be required to predict infallibly how a court will rule. A lawyer would need a crystal ball, along with his library, to be able to guarantee that no judge, anytime, anywhere, would disagree with his judgment or evaluation of a situation." Similarly, this Court refuses to impose any greater duty on attorneys than to act as would an attorney of ordinary learning, judgment, or skill under the same or similar circumstances.

Lastly, mere errors in judgment by a lawyer are generally not grounds for a malpractice action where the attorney acts in good faith and exercises reasonable care, skill, and diligence. *Baker v Beal, 225 NW2d 106, 112 (Iowa, 1975)*. Where an attorney acts in good faith and in honest belief that his acts and omissions are well founded in law and are in the best interest of his client, he is not answerable for mere errors in judgment. *Rorrer v Cooke, 313 NC 338, 340-342; 329 S.E.2d 355 (1985)*. See also *7 Am Jur 2d, Attorneys at Law, §§ 201-202*, pp 250-252; 7A CJS, Attorney & Client, §§ 257-258, pp 464-472; 1 Mallen & Smith, Legal Malpractice (3d ed), §§ 14.12 to 14.17, pp [***13] 836-853:

> There can be no liability for acts and omissions by an attorney in the conduct of litigation which are based on an honest exercise of professional judgment. This is a sound rule. Otherwise every losing litigant would be able to sue his attorney if he could find another attorney who was willing to second guess the decisions of the first attorney with the advantage of hindsight
>
> . . . . To hold that an attorney may not be held liable for the choice of trial tactics and the conduct of a case based on professional judgment is not to say, however, that an attorney may not be held liable for any of his actions in relation to a trial. He is still bound to exercise a reasonable degree of skill and care in all his professional undertakings. *[Woodruff* [*659] *v Tomlin, 616 F2d 924, 930 (CA, 1980)* (citations omitted).]

IV

We find that the defendant acted as would an attorney of ordinary learning, judgment, or skill under the same or similar circumstances, and his alleged acts and omissions were a matter of trial tactics based on reasonable professional judgment.

From October 12 through October 15, 1987, Mr. Simko's trial was held in the Recorder's Court for the City of [***14] Detroit, before the Honorable Craig S. Strong. Mr. Simko [**848] was the only witness to testify. Dr. Karbal and Mrs. Simko were not called as witnesses because Mr. Blake did not feel that they would be beneficial to the defense's case. Following the prosecution's presentation of the case, and again after the defense rested, Mr. Blake moved for a directed verdict of acquittal. Both motions were denied by Judge Strong. On October 15, 1987, Mr. Simko was convicted by the jury as charged.

We find, as a matter of law, that the plaintiffs' allegations could not support a breach of duty because they are based on mere errors of professional judgment and not breaches of reasonable care. Plaintiffs' allegations of breach of duty are contained in PP 10(a)-(k) of plaintiffs' complaint. The only specific allegations that could have altered the outcome of Mr. Simko's trial are contained in PP 10(d)-(i). [5] Plaintiffs alleged that defendant should have called other witnesses besides [*660] Mr. Simko, including Mr. Simko's physician, Dr. Michael Karbal, and Mr. Simko's wife, Margaret Simko. In addition, P 10(i) alleges that Mr. Blake failed to ascertain the name and location of the hotel where Mr. Simko had allegedly [***15] spent the day before he was arrested.

5 Paragraphs 10(a)-(c) will not be discussed herein because they are general allegations and do not indicate how the outcome of the trial would have been effected. Also PP 10(j)-(k) are conclusory, and, again, do not specifically show how the trial would have been affected or how the defendant may have acted differently.

First, it is a tactical decision whether to call particular witnesses, as long as the attorney acts with full knowledge of the law and in good faith. *Woodruff, supra at 933. Woodruff* held that a charge of malpractice on the basis of an attorney's decision to not cross-examine an expert witness did not constitute malpractice. Similarly, in *Frank v Bloom, 634 F2d 1245, 1256-1257 (CA*

79

10, 1980), the court stated that it will afford latitude to the attorney when making tactical strategies:

> It is the duty of the attorney who is a professional to determine trial strategy. If the client had the last word on this, the client could be his or [***16] her own lawyer.

See also *Kirsch v Duryea, 21 Cal 3d 303; 578 P2d 935, 146 Cal. Rptr. 218 (1978)*, *Fishow v Simpson, 55 Md App 312; 462 A2d 540 (1983)*, and *Burk v Burzynski, 672 P2d 419 (Wy, 1983)*.

Here, plaintiffs are alleging that defendant was negligent in not calling Dr. Karbal and Mrs. Simko. This, however, is a tactical decision that this Court may not question. Perhaps defendant made an error of judgment in deciding not to call particular witnesses, and perhaps another attorney would have made a different decision; however, tactical decisions do not constitute grounds for a legal malpractice action. *Woodruff, supra.* Plaintiffs' claim that certain witnesses should have been called is nothing but an assertion that another lawyer might have conducted the trial differently, [*661] a matter of professional opinion that does not allege violation of the duty to perform as a reasonably competent criminal defense lawyer.

Second, the failure to ascertain the name and location of the hotel where a client was located at a particular time does not constitute negligence. There is no duty to infallibly protect a client from impeachment. This would be an impossible [***17] standard for defense counsel to meet and would violate and extend beyond the well-established reasonable care standard. See *Lipton, supra at 594*; *Babbitt, supra at 337*.

V

We conclude that there was no legal basis for holding that Mr. Blake's actions constituted negligence, or otherwise constitute malpractice. When an attorney fashions a trial strategy consistent with the governing principles of law and reasonable professional judgment, the attorney's conduct is legally adequate. Accordingly, we affirm the decision of the Court of Appeals and hold that the defendant fulfilled his duty to his client.

Conrad L. Mallett, Jr.

Michael F. Cavanagh

Patricia J. Boyle

Dorothy Comstock Riley

DISSENT BY: Charles L. Levin

DISSENT

[**849] LEVIN, J. (*dissenting*).

This is an action for legal malpractice. Plaintiff Arthur Louis Simko was convicted of possessing over 650 grams of cocaine and sentenced to the mandatory term of life in prison. [1] Defendant Marvin Blake represented [*662] Simko at the trial. His motion for a directed verdict was denied.

> 1 *MCL 333.7401(2) (a) (i)*; MSA 14.15(7401) (2) (a) (i).
>
> He was also convicted of possession of a firearm in the commission or attempt to commit a felony. *MCL 750.227b*; MSA 28.424(2).

[***18] The Court of Appeals [2] reversed Simko's conviction finding that there was insufficient evidence that Simko possessed the cocaine found in the vehicle in which he was a passenger. The Court thus implicitly ruled that Blake's motion in Simko's behalf for a directed verdict should have been granted.

> 2 Unpublished opinion per curiam, issued November 29, 1989 (Docket No. 105873).

Although Simko's conviction was reversed without a new trial, he was imprisoned under a life sentence for more than two years. Simko, his wife, Margaret A. Simko, and his daughter, Tara Marie Simko, commenced this action against Blake alleging errors of omission and commission and failure to observe the standard of care required of a lawyer.

The circuit judge granted Blake's motion for summary disposition, dismissing the complaint because he concluded that the "proximate cause" of Blake's conviction was the trial judge's error in denying Blake's motion for a directed verdict and the "unreasonable jury" verdict of guilty.

The Court [***19] of Appeals acknowledged that "proximate cause in attorney malpractice is a question for the trier of fact, and "*accept[ed] that a trier of fact could find that it was because Blake did not present additional evidence that Simko spent two years in prison unnecessarily.*" [3] The Court nevertheless affirmed, one judge dissenting, on the basis that Blake had discharged his "duty" to Simko when he "identified correctly the legal inadequacy" of the people's case and thus had no duty to "be prepared to present additional evidence in [*663] support of alternative theories just in case the trial court erroneously should deny the motions." [4]

> 3 *201 Mich App 191, 193; 506 NW2d 258 (1993)*.

4 *Id., p 194.*

The majority, adopting essentially the same analysis, affirms. I would reverse the Court of Appeals and reinstate the complaint because, although stated in terms of "duty, the majority in this Court

> . essentially ignores that Blake's motion asserted that the requisite causal link [5] was absent, and did [***20] not seek a redefinition of the duty owing by, or the standard of care required of, a lawyer;
>
> . in effect redefines the standard of care to require of a lawyer less than ordinary learning, judgment, diligence, and skill in the representation of a client;
>
> . in effect invades the province of the trier of fact by finding that "the" only cause/proximate cause of Simko's injury was the trial judge's error in denying the motion for directed verdict rather than allowing the trier of fact to determine whether "a" cause was error by Blake;
>
> . indulges in further fact finding in stating that Blake's "alleged acts and omissions were trial tactics based on good faith and reasonable professional judgment." [6]

5 Blake moved for summary disposition on the basis that the Simkos "failed to state a claim on which relief can be granted" [*MCR 2.116(C) (8)*] because "the proximate cause of [Blake's] convictions was the trial court's error in denying the Motion for a Directed Verdict of not guilty."

6 Slip op, p 2.

[***21] A physician who operated successfully on a patient, whose malady could have been cured with a pill that a physician of ordinary learning, judgment, [*664] diligence or skill would have administered, would be subject to liability for the unnecessary inconvenience, pain, and suffering, even if endured for only a few weeks, and not two years. So, too, should a lawyer be subject to liability if the trier of fact finds that a lawyer of ordinary learning, judgment, diligence, and skill would have advanced alternative [**850] theories that would have avoided Simko enduring over two years' imprisonment.

The Supreme Court of North Dakota ruled in a legal malpractice action, *Klem v Greenwood, 450 NW2d 738, 744 (ND, 1990)*, that "merely because this court reversed Klem's conviction does not mean that any alleged malpractice caused no damage." The court said that in holding that the trial court had erred and that Greenwood, Klem's lawyer, had preserved the issue for appellate review, the court "did not hold, as a matter of law, that Greenwood had met the degree of skill, care, *diligence,* and knowledge commonly possessed and exercised by a reasonable, careful, and prudent attorney." (Emphasis added.) [***22] [7]

7 The court observed that Klem had alleged "acts of malpractice, including, but not limited to, the failure to adequately cross-examine a complaining witness."

I

The majority states:

> Attorneys must only act as would an attorney of ordinary learning, judgment, or skill under the same or similar circumstances." [8]

8 Slip op, p 1.

A

I agree that a lawyer need "only act" as would a [*665] lawyer of ordinary learning, judgment, diligence, or skill under the same or similar circumstances. But he must *so act.* If the majority were to allow this case to come to trial, the evidence were to show, and a trier of fact were to find, that a lawyer of ordinary learning, judgment, diligence, or skill, under the same or similar circumstances, would have avoided errors that Blake allegedly committed, then Blake is, or should be, subject to [***23] liability for damage found to have resulted from conviction of an offense subjecting Simko to a sentence of life in prison and actual incarceration for over two years.

In holding as a matter of law that Blake is not subject to liability because it was ultimately determined that he interposed a legally adequate defense even though, had he avoided error, Simko would not have been convicted and served over two years in prison, the majority requires less of Blake than the conduct of a lawyer of "ordinary learning, judgment, or skill under the same or similar circumstances."

B

The majority also states that "mere errors in judgment by a lawyer are *generally* not grounds for a malpractice action where the attorney acts in good faith and exercises reasonable care, skill, and diligence." [9] (Emphasis added.) It is implicit in the formulation adopted by the majority, requiring a lawyer to act as would a lawyer of "ordinary learning, *judgment,* or skill," [10] that errors of judgment may constitute negligence. Whether an error of judgment, or a "mere" error of judgment, constitutes [*666] negligence depends on whether a lawyer of ordinary learning, judgment, diligence, or skill would have avoided [***24] the error or "mere" error of judgment. That "generally" is a question of fact for the trier of fact to decide.

9 Slip op, p 10.

10 Slip op, p 1, quoted in text accompanying n.8.

II

Manifestly, no trial lawyer would long remain solvent if he were required to protect against judicial error or "unreasonable" jury verdicts. It is the experience of most lawyers that they win cases they expect to lose, and lose cases they expect to win.

It is because lawyers cannot safely predict that a trial judge will avoid error or that an appellate court will both recognize and correct an error, that a lawyer of ordinary learning, judgment, diligence, and skill does not--and it is, and should be, legal malpractice to--bet his client's life on prevailing on one issue that he believes is "legally sufficient to fully vindicate" [11] his client's position, eschewing other viable means of defense.

11 Slip op, p 1.

[**851] [***25] In *Dedes v Asch, 446 Mich 99; 521 NW2d 488 (1994)*, this Court ruled that to be actionable, negligent misconduct need be only "a" cause and need not be "the" cause of the injury. Today the majority announces a special rule for lawyer negligent misconduct, relieving lawyers of liability for failure to advance alternative theories or defenses that should have been advanced to observe the standard of care if it is ultimately determined that, but for judicial or jury error, plaintiffs' loss would have been avoided.

III

Blake's motion for summary disposition was filed [*667] on the basis that the Simkos "failed to state a claim on which relief can be granted." [12] In finding facts on this second appellate review, the majority ignores that only the pleadings may be considered by the circuit court and the appellate courts in ruling on such a motion.

12 *MCR 2.116(C)(8).*

The majority finds, as a matter of fact or law, that the "alleged acts and omissions were trial tactics based on good faith and reasonable professional [***26] judgment." [13] The complaint particularized concerning the errors claimed by Simko. [14] In response to the motion for summary disposition, the Simkos filed an affidavit of a lawyer stating that in his opinion Blake had erred. Blake did not file an affidavit in support of the motion for summary disposition, probably because no such support is required or permitted. [15] Nevertheless the majority finds, as a matter of fact or law, that Blake acted in good faith and exercised reasonable professional judgment.

13 Slip op, p 2.

14 The particularized claims are summarized in the majority opinion, pp 3-5, n 2.

15 *MCR 2.116(G) (5).*

The majority finds, as a matter of fact or law, that certain witnesses were not called because Blake "did not feel that they would be beneficial to the defense's case." [16]

16 Slip op, p 12.

Because [***27] Blake did not file an affidavit in support of his motion for summary disposition, and, even if he had, it could not properly have been considered in deciding the motion, there is no record support for fact finding by the majority.

Because there is no factual record, the majority does not have a basis for asserting that the witnesses were not called because Blake "did not feel [*668] that they would be beneficial to defense's case." [17] Since there is no record, we do not know whether either or both witnesses were interviewed by Blake, and what might have occurred during any such interview. The silent record no more justifies a finding that Blake had a reason for not calling the witnesses, than it would a finding that he simply neglected or overlooked calling them. A silent record Supports no finding of fact at all.

17 *Id.*

IV

The majority states, quoting with approval the opinion of the Court of Appeals:

"To impose a duty on attorneys to do more than that which is legally adequate to fully vindicate a client's [***28] rights would require 'our legal system, already overburdened, to digest unnecessarily inordinate quanti-

ties of additional motions and evidence that, in most cases, will prove to be superfluous." [18]

18 Slip op, p 10, quoting *Simko* v *Blake, supra,* p 194.

If lawyers were omniscient about trial and appellate court rulings that will be forthcoming in a particular case, they would know what motions were unnecessary. If trial judges were omniscient about appellate court rulings, they would rarely err. It is because a lawyer cannot assuredly predict such rulings that an ordinarily careful, prudent, diligent, and skillful lawyer burdens the legal system with motions that, in retrospect, may have been unnecessary.

The Simkos are not complaining that Blake failed to paper this case as commonly occurs in high-stakes civil litigation. Indeed, they do not claim that Blake failed to file a motion, [**852] "additional" [*669] or otherwise. They complain, rather, about his asserted lack of diligence in preparing for trial, [***29] and in failing to call witnesses during trial. [19]

19 Slip op, p 3, n 2.

Lowering the standard of care for lawyers will not reduce the burden of over-lawyering by lawyers who fail to recognize their professional responsibility. Lowering the standards will not raise the level of professional responsibility.

V

In *Gebhardt v O'Rourke, 444 Mich 535, 554; 510 NW2d 900 (1994)*, this Court said that "successful post-conviction relief is not a prerequisite to the maintenance of a claim for legal malpractice arising out of negligent representation in a criminal matter." The Court, thus, implicitly said that a legal malpractice action may be maintained against a lawyer who represented a plaintiff in a criminal matter without establishing that he rendered "ineffective assistance." [20]

20 See *People v Pickens, 446 Mich 298; 521 NW2d 797 (1994).*

[***30] Simko is at least entitled to maintain this damage action for legal malpractice if he can establish that Blake failed to render effective assistance within the meaning of the "ineffective assistance" standard. [21] The majority should at least remand to the circuit court for determination of the effective assistance issue. [22]

21 Simko sought reversal in the Court of Appeals not only on the basis of insufficiency of the evidence but also on the basis that he was denied the effective assistance of counsel. Because the Court of Appeals reversed his conviction on the basis that there was insufficient evidence, it did not reach the question whether he was denied the effective assistance of counsel. Simko thus did not obtain a ruling from the Court of Appeals on his claim that he was denied the effective assistance of counsel.

22 In *Gebhardt, supra at 548, n.13*, this Court said:

> We do not accept the "no relief-no harm" rule because it is a legal fiction with serious analytical flaws. n.13

Rather than being a legal definition of harm, the rule is a legal fiction that divorces the law from reality. "Persons convicted of a crime will be astonished to learn that, even if their lawyers' negligence resulted in their being wrongly convicted and imprisoned, they were not harmed when they were wrongly convicted and imprisoned but, rather, that they are harmed only if and when they are exonerated."

The Court also said at 552:

However, as the Court in *Luick* [v *Rademacher, 129 Mich App 803; 342 NW2d 617 (1983)] at 807, n 1*, noted, *Parisi* [v *Michigan Twps Ass'n, 123 Mich App 512; 332 NW2d 587 (1983)]* "does not provide an answer to the question now before us. . . . In this case, a cause of action for malpractice could well exist regardless of the outcome of post-judgment proceedings in the underlying case."

[*670] [***31]

We would reverse the Court of Appeals and remand for determination under the standard of care heretofore applicable in actions asserting legal malpractice in the conduct of criminal as well as civil cases.

Charles L. Levin

James H. Brickley

2 of 3 DOCUMENTS

Analysis
As of: May 21, 2012

ARTHUR LOUIS SIMKO, MARGARET A. SIMKO, and TARA MARIE SIMKO, Plaintiffs-Appellants, v. MARVIN BLAKE, Defendant-Appellee.

SC: 97579

SUPREME COURT OF MICHIGAN

445 Mich. 861*; *519 N.W.2d 159*; *1994 Mich. LEXIS 748

April 20, 1994, Entered

PRIOR HISTORY: [*1] COA: 135977. LC: 89-926492-NM

JUDGES: Michael F. Cavanagh, Chief Justice, Charles L. Levin, James H. Brickley, Patricia J. Boyle, Dorothy Comstock Riley, Robert P. Griffin, Conrad L. Mallett, Jr., Associate Justices

OPINION

Order

On order of the Court, the application for leave to appeal is considered, and it is GRANTED.

54

Caution
As of: May 21, 2012

ARTHUR LOUIS SIMKO, MARGARET A. SIMKO, and TARA MARIE SIMKO, Plaintiffs-Appellants, v. MARVIN BLAKE, Defendant-Appellee.

Docket No. 135977

Court of Appeals of Michigan

201 Mich. App. 191*; *506 N.W.2d 258*; *1993 Mich. App. LEXIS 315

January 12, 1993, Submitted
August 16, 1993, Decided

SUBSEQUENT HISTORY: Leave to appeal sought.

PRIOR HISTORY: [***1] LC No. 89-926492 NM.

DISPOSITION: Affirmed.

COUNSEL: *Blaske & Blaske, P.C.* (by *E. Robert Blaske*), for the plaintiffs.

Plunkett & Cooney, P.C. (by *Christine D. Oldani* and *Patrick M. Burrett*), for the defendant.

JUDGES: Connor, P.J., and Holbrook, Jr., and McDonald, JJ. Holbrook, Jr., J., concurred. McDonald, J. (*dissenting*).

OPINION BY: CONNOR

OPINION

[*192] [**259] Plaintiffs appeal as of right the trial court's dismissal of their legal malpractice action pursuant to *MCR 2.116(C)(8)*. We affirm.

In 1987, plaintiff Arthur Simko was tried for possession with intent to deliver more than 650 grams of cocaine, *MCL 333.7401(2)(a)(i)*; MSA 14.15(7401)(2)(a)(i), and possession of a firearm during the commission of a felony, *MCL 750.227b*; MSA 28.424(2). His attorney, defendant, Marvin Blake, moved for a directed verdict at the close of the prosecution's case, arguing that there was insufficient evidence of Simko's guilt. The motion was denied. Blake called only Simko to testify in his own defense, then argued to the jury that there was insufficient evidence of Simko's guilt. The jury found Simko guilty of both crimes, and he was sentenced to life in prison. Simko appealed, and this Court, almost two years later, agreed that the evidence was insufficient and reversed Simko's convictions. *People v Simko,* unpublished opinion per curiam of the Court of Appeals, decided November 29, 1989 (Docket No. 105873).

[*193] Simko sued Blake for malpractice. We accept all Simko's factual allegations as true, as well as any reasonable inferences or conclusions that can be drawn from the facts. *Parkhurst Homes, Inc v McLaughlin, 187 Mich App 357, 360; 466 NW2d 404 (1991)*. Therefore, we accept that Blake could have presented additional evidence to the jury that would have so convinced them of Simko's innocence that they would not have wrongfully convicted him. Proximate cause in attorney malpractice is a question for the trier of fact. *Charles Reinhart Co v Winiemko, 196 Mich App 110, 113; 492 NW2d 505 (1992)*. Consequently, we accept that a trier of fact could find that it was because Blake did not pre-

sent additional evidence that Simko spent two years in prison unnecessarily.

To state a claim of legal malpractice, Simko must show the existence of the client-attorney relationship, the acts constituting negligence, that the negligence was the proximate cause of injury, and the existence and extent of the injury. *Espinoza v Thomas, 189 Mich App 110, 115; 472 NW2d 16 (1991)*. Central to any negligence claim is duty: the idea that a defendant was under an obligation for the benefit of a particular plaintiff. *Buczkowski v McKay, 441 Mich 96, 100; 490 NW2d 330 (1992)*.

An attorney has a duty to represent a client's interests. Plaintiffs' claim tests how far that duty extends. Plaintiffs contend that an attorney has a duty to do more than that which is minimally adequate to win a client's case. Because it is foreseeable that a trial court will rule incorrectly, and because it is foreseeable that a jury will convict someone unjustly, plaintiffs argue that an attorney has a duty to protect a client from those foreseeable errors where possible.

The mere fact that something is foreseeable does not impose a duty on a defendant. *Id. at 101.* [*194] "Duty" is an expression of the policy considerations that lead the law to say that the plaintiff is entitled to protection. *Id. at 100-101*. Factors to be considered when determining whether a duty exists include: foreseeability of the harm, degree of certainty of the injury, moral blame attached to the conduct, policy of preventing future harm, and the burdens and consequences of imposing a duty and the resulting liability for breach. *Id. at 101, n 4.*

There is no motion that can be filed, no amount of research in preparation, no level of skill, nor degree of perfection that could anticipate every error or completely shield a client from the occasional aberrant ruling of a fallible judge or an intransigent jury. To impose a duty on attorneys to do more than that which is legally adequate to fully vindicate a client's rights would require our legal system, already overburdened, to digest unnecessarily inordinate quantities of additional motions and evidence that, in most cases, will prove to be superfluous. And, because no amount of work can guarantee a [**260] favorable result, attorneys would never know when the work they do is sufficiently more than adequate to be enough to protect not only their clients from error, but themselves from liability.

We will not impose a duty on attorneys to do more for a client than that which is legally adequate to vindicate fully the client's interests. We believe it would impose an unreasonable burden to require that an attorney who has identified correctly the legal inadequacy of his opponent's case and has tendered the appropriate motions to the court also be prepared to present additional evidence in support of alternative theories just in case the trial court erroneously should deny the motions. Attorneys and clients must be free to [*195] negotiate among themselves about how to deal with the risks of a mistake. Clients who do not want to take the risk, and can afford it, can contract with their attorneys for whatever extra work is needed to lessen the risk to a level they find acceptable. In the absence of some special agreement, defendants are entitled only to legally adequate representation, and they must accept the risk that the just resolution of their legal problem will have to wait for an appellate court's decision.

In this case, Simko retained Blake to help defend him against two criminal charges. By challenging the sufficiency of the evidence against Simko, Blake raised a complete and ultimately successful defense to both charges. It is unfortunate that the success of Blake's defense was delayed until this Court could correct the errors that had been made below. However, Blake was not Simko's insurer against all possible misfortune; he was his criminal defense lawyer. His duty was to raise an adequate defense to the criminal charges, not to protect Simko from judge and jury.

Affirmed.

DISSENT BY: McDONALD

DISSENT

McDonald, J. (*dissenting*).

I respectfully dissent. I believe the trial court erred in granting defendant's motion for summary disposition pursuant to *MCR 2.116(C)(8)*, failure to state a claim upon which relief can be granted.

The trial court granted defendant's motion for summary disposition because it found the proximate cause of plaintiffs' injuries to be the criminal trial court's error in failing to grant plaintiff Arthur Simko's motion for a directed verdict. However, it is well settled that there may be more than one proximate cause for the same injury. [*196] *Arbelius v Ploetti, 188 Mich App 14; 469 NW2d 436 (1991)*. Thus, the trial court's finding the criminal trial court's error to be a proximate cause of plaintiffs' injuries did not preclude a finding that defendant's actions likewise constituted a proximate cause of the injuries. Plaintiffs' complaint set forth a prima facie case of legal malpractice. It alleged the existence of a client-attorney relationship, negligence resulting from defendant's failure to present an adequate defense in the criminal trial, and that defendant's failure to present an adequate defense was the proximate cause of plaintiff Arthur Simko's imprisonment and related injuries. *Es-*

pinoza v Thomas, 189 Mich App 110; 472 NW2d 16 (1991).

I agree with that portion of the majority opinion that states an attorney is not a guarantor of a trial free from error and has no duty "to do more for a client than that which is legally adequate to vindicate fully the client's interests." However, the majority's application of this principle without analysis begs the question. The question presented by plaintiffs' complaint is whether defendant's actions were in fact "legally adequate to vindicate fully" plaintiffs' rights. Plaintiffs, having set forth a valid claim, are entitled to a determination of this issue. I would find summary disposition was improperly granted.

M Civ JI 30.04 Medical Malpractice: Cautionary Instruction on Medical Uncertainties

There are risks inherent in medical treatment that are not within a doctor's control. A doctor is not liable merely because of an adverse result. However, a doctor is liable if the doctor is negligent and that negligence is a proximate cause of an adverse result.